



**REPORT OF THE AUDITOR OF PUBLIC ACCOUNTS  
AUDIT OF THE CABINET FOR HEALTH SERVICES**

**Made as Part of the Statewide Single Audit  
of the Commonwealth of Kentucky**

**For the Year Ended June 30, 2000**

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**EXECUTIVE SUMMARY**  
**REPORT OF THE AUDITOR OF PUBLIC ACCOUNTS**  
**AUDIT OF THE CABINET FOR HEALTH SERVICES**  
**FOR THE YEAR ENDED JUNE 30, 2000**

**BACKGROUND:**

The Single Audit Act of 1984, subsequent amendments, and corresponding regulations, requires the auditing of financial statements and the compliance and internal controls applicable to federal moneys received by the Cabinet for Health Services. To comply with these requirements, we audited internal controls and compliance at both the central and agency level. This summary pertains to our audit of one organizational unit of the Commonwealth, the Cabinet for Health Services.

The Cabinet for Health Services is the state government agency that administers programs to promote mental and physical health for Kentucky's citizens. The Cabinet seeks to provide quality healthcare and related services, as well as seeking to expand eligibility and control rising health care costs, for eligible persons for programs administered by the Cabinet.

**EXPENDITURES:**

The Cabinet for Health Services expended federal awards totaling \$2,443,618,786 in the following manner:

- \$2,435,393,250 in cash from 9 federal grantors
- \$8,225,536 in noncash grants (i.e., vaccines)

**SUMMARY OF AUDITOR'S RESULTS:**

**Financial Statement Accounts**

Compliance: No instances of noncompliance

Internal Control Over Financial Reporting: Three (3) other matter comments

**Federal Awards and Schedule of Expenditures of Federal Awards**

Compliance: No instances of noncompliance

Internal Control Over Compliance: Six (6) reportable conditions, none of which are material weaknesses and Five (5) other matters

**Financial Statement Other Matters**

- Cash Receipts
- Medical Assistance Program

**Federal Programs with Reportable Conditions**

- Substance Abuse Block Grant
- Medical Assistance Program

**Federal Programs with Other Matter Comments**

- Medical Assistance Program
- Schedule of Expenditures of Federal Awards



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## **INTRODUCTION**





**CABINET FOR HEALTH SERVICES  
INTRODUCTION  
FOR THE YEAR ENDED JUNE 30, 2000**

**Introduction**

The Auditor of Public Accounts (APA), acting as principal auditor in conjunction with various certified public accounting firms, annually performs a statewide single audit of the Commonwealth of Kentucky. This audit allows the Commonwealth to comply with federal audit requirements as set forth in the Single Audit Act of 1984, as amended by Public Law 104-156, and the regulations contained in the U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*.

**Schedule of Expenditures of Federal Awards**

This report contains the Schedule of Expenditures of Federal Awards for the Cabinet for Health Services (CHS). The Notes to the Schedule of Expenditures of Federal Awards follows the schedule to provide more detailed information on certain aspects of the expenditures, such as the amount given to subrecipients.

Since not all state agencies use the Management Administrative Reporting System (MARS) Subsystems for Projects, the APA requested CHS to prepare worksheets of federal financial assistance, both cash and noncash. The source of these worksheets included MARS, agency accounting systems, agency manual records, etc. CHS was also asked to reconcile the worksheets to MARS and to federal grantor reports. These worksheets were compiled into the accompanying Schedule of Expenditures of Federal Awards.

**Schedule of Findings and Questioned Costs**

The Schedule of Findings and Questioned Costs consists of three sections:

- Summary of Auditor's Results
- Financial Statement Findings
- Federal Award Findings and Questioned Costs

Each audit finding number and the audit finding's classification (as reportable, material, or other matters) is provided as part of the audit opinion summary. Major programs audited are listed on the Summary of Auditor's Results. The second part is the Financial Statement Findings. This part lists all the audit findings related to the financial statements. The third part, the Federal Award Findings and Questioned Costs, lists all findings related to federal awards. Generally, the state agency, CFDA number and program, federal agency, pass-through agency, and the compliance area the finding relates to are presented. In both parts two and three, reportable conditions and reportable conditions of noncompliance are presented first, then material weaknesses and material instances of noncompliances, followed by other matters.

**CABINET FOR HEALTH SERVICES  
INTRODUCTION  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**Summary Schedule of Prior Audit Findings**

Audit findings reported in the Schedule of Findings and Questioned Costs for the fiscal year ended June 30, 1999 (as well as any previous finding which have not been resolved) are reported in CHS' Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2000. If the APA determines the agency's Summary Schedule of Prior Audit Findings materially misrepresents the status of any prior audit finding, a new audit finding is issued and reported in the Schedule of Findings and Questioned Costs.

The Summary Schedule of Prior Audit Findings is organized based on whether the prior year finding was reportable, material, or other matter. The findings of each classification are categorized as (1) fully corrected, (2) not corrected or partially corrected, (3) corrective action taken differs significantly from corrective action previously reported, or (4) finding no longer valid or does not warrant further action. If a finding has been reclassified, from material to reportable for instance, the finding will appear in the material finding section of the summary schedule and the comment will indicate the reclassification. In the following year, the finding will appear in the reportable section of the summary schedule.

**Audit Approach**

Our audit was conducted in accordance with the Single Audit Act Amendments of 1996, OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, *Government Auditing Standards* (also referred to as the Yellow Book), and generally accepted auditing standards. The scope of the statewide single audit for the year ended June 30, 2000 included:

- An audit of the general-purpose financial statements and required supplementary schedules in accordance with generally accepted government auditing standards;
- An audit of supplementary Schedule of Expenditures of Federal Awards in accordance with generally accepted government auditing standards;
- An audit of the internal control applicable to CHS to the extent necessary to consider and test the internal accounting and administrative control systems as required; and
- A selection and testing of transactions and records relating to each major federal financial assistance program to obtain reasonable assurance that CHS administers its major federal financial assistance programs in compliance with laws and regulations for which noncompliance could have a material effect on the allowability of program expenditures or on the Commonwealth's general-purpose financial statements.

**CABINET FOR HEALTH SERVICES  
INTRODUCTION  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**Audit Approach (Continued)**

The APA conducted the audit of internal control, focusing on the following objectives:

- Considering the internal control in order to determine auditing procedures on the general-purpose financial statements of the Commonwealth.
- Determining if CHS has internal controls to provide reasonable assurance that it is managing the federal assistance programs in compliance with applicable laws and regulations.

**List of Abbreviations/Acronyms Used In This Report**

AICPA	American Institute of Certified Public Accountants
APA	Auditor of Public Accounts
CDP	Custom Data Processing
CFDA	Catalog of Federal Domestic Assistance
CFR	Code of Federal Regulations
CHS	Cabinet for Health Services
CLIA	Clinical Laboratory Improvement Act
CMHC	Community Mental Health Center
DMH/MR	Department for Mental Health and Mental Retardation
DMS	Cabinet for Health Services, Department for Medicaid Services
DRP	Drug Rebate Program
FAC	Finance and Administration Cabinet
FFA	Federal Financial Assistance
FFY	Federal Fiscal Year
FI	Food Instruments
FY	Fiscal Year
FYE	Fiscal Year Ended
GUI	Graphical User Interface System
HCFA	Health Care Financing Administration
ICF/MR/DD	Intermediate Care Facilities/Mental Retardation/Developmentally Disabled
JCAHO	Joint Commission on Accreditation of Hospitals
KAR	Kentucky Administrative Regulations
KD&A	Consolidated Development and Application Program
KMAP	Kentucky Medicaid Assistance Program
KRS	Kentucky Revised Statute
KTOS	Department Treatment Outcome Study
L&R	Division of Licensing and Regulation
MAP	Medical Assistance Program
MARS	Management Administrative Reporting System
MMIS	Medical Management Information System

**CABINET FOR HEALTH SERVICES  
INTRODUCTION  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**List of Abbreviations/Acronyms Used In This Report (Continued)**

NA	Not Applicable
NDC	National Drug Code
NF	Nursing Facilities
OADES	Optical Character Recognition-Assisted Data Entry System
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of Inspector General
OMB	Office of Management and Budget
PATH	Projects for Assistance in Transition from Homelessness
PDS	Prevention Data Set
PP File	Prescribing Provider File
PRO	Peer Review Organization
RCW	Record of Control Weakness
RPC	Regional Prevention Center
RUMBA	The part of the Medical Management Information System which records provider data
SA	Division of Substance Abuse
SAPT	Substance Abuse Prevention and Treatment
SBOP	Kentucky State Board of Pharmacy
SFY	State Fiscal Year
SNF	Skilled Nursing Facility
SOP	Statement of Position
STARS	Statewide Accounting and Reporting System
TANF	Temporary Assistance for Needy Families
UNISYS	The corporation under contract with CHS to process Medicaid claims
U.S.	United States
USC	United States Code
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

**SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS**



**CABINET FOR HEALTH SERVICES  
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS  
FEDERAL ASSISTANCE PROGRAMS  
FOR THE YEAR ENDED JUNE 30, 2000**

State Agency		Pass Through Grantor's #	Expenditures	
Federal Grantor	CFDA # Program Title		Cash	Noncash
<b><u>CABINET FOR HEALTH SERVICES</u></b>				
<b><u>U.S. Department of Agriculture</u></b>				
<b>Direct Programs:</b>				
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children (Note 2) (Note 4)	N/A	\$ 82,628,276	
10.570	Nutrition Program for the Elderly (Commodities) (Note 4)	N/A	1,813,041	
<b>Passed Through From Cabinet for Families and Children:</b>				
10.561	State Administrative Matching Grants for Food Stamp	N/A	167,999	
<b><u>U.S. Department of Justice</u></b>				
<b>Passed Through From Justice Cabinet:</b>				
16.579	Byrne Formula Grant Program	N/A	104,860	
<b><u>U.S. Department of Labor</u></b>				
<b>Direct Programs:</b>				
17.235	Senior Community Services Employment Program (Note 4)	N/A	1,618,611	
<b>Passed Through From Cabinet for Families and Children:</b>				
17.253	Welfare-to-Work Grants to States and Localities	N/A	171	
<b><u>U.S. Environmental Protection Agency</u></b>				
<b>Direct Programs:</b>				
66.032	State Indoor Radon Grants (Note 4)	N/A	219,814	
66.606	Surveys, Studies, Investigations and Special Purpose Grants	N/A	61,045	
66.707	TSCA Title IV State Lead Grants-Certification of Lead-Based Paint Professionals	N/A	342,202	
<b><u>U.S. Department of Energy</u></b>				
<b>Passed Through From Cabinet for Families and Children:</b>				
81.042	Weatherization Assistance for Low-Income Persons	N/A	26,623	

See accompanying notes to the Schedule of Expenditures of Federal Awards

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS  
FEDERAL ASSISTANCE PROGRAMS  
FOR THE YEAR ENDED JUNE 30, 2000**

State Agency Federal Grantor CFDA # Program Title	Pass Through Grantor's #	Expenditures	
		Cash	Noncash

**CABINET FOR HEALTH SERVICES (CONTINUED)**

**U.S. Department of Energy (Continued)**

**Passed Through From Natural Resources And Environmental Protection Cabinet:**

81.502	Paducah Gaseous Diffusion Plant Environmental Monitoring and Oversight (Note 4)	DE-FG05-910R21997	\$	414,049
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**U.S. Federal Emergency Management Agency**

**Passed Through From Military Affairs:**

83.549	Chemical Stockpile Emergency Preparedness Program (Note 4)	N/A		107,554
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**U.S. Department of Education**

**Direct Programs:**

84.181	Special Education - Grants for Infants and Families with Disabilities (Note 4)	N/A		3,799,199
84.186	Safe and Drug-Free Schools and Communities - State Grants (Note 4)	N/A		1,419,662
84.323	Special Education -- State Program Improvement Grants for Children with Disabilities (Note 4)	N/A		22,655

**U.S. Department of Health and Human Services**

**Direct Programs:**

93.041	Special Programs for the Aging - Title VII, Chapter 3 - Programs for Prevention of Elder Abuse, Neglect, and Exploitation (Note 4)	N/A		65,500
93.042	Special Programs for the Aging - Title VII, Chapter 2 - Long-term Care Ombudsman Services for Older Individuals (Note 4)	N/A		121,147
93.043	Special Programs for the Aging - Title III, Part F - Disease Prevention and Health Promotion Services (Note 4)	N/A		219,037
93.044	Special Programs for the Aging - Title III, Part B - Grants for Supportive Services and Senior Centers (Note 4)	N/A		4,685,894
93.045	Special Programs for the Aging - Title III, Part C - Nutrition Services (Note 4)	N/A		6,962,947
93.046	Special Programs for the Aging - Title III, Part D - In-Home Services for Frail Older Individuals (Note 4)	N/A		96,374
93.048	Special Programs for the Aging - Title IV, Training, Research, and Discretionary Projects and Programs (Note 4)	N/A		99,113

See accompanying notes to the Schedule of Expenditures of Federal Awards



**CABINET FOR HEALTH SERVICES  
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS  
FEDERAL ASSISTANCE PROGRAMS  
FOR THE YEAR ENDED JUNE 30, 2000**

State Agency		Pass Through Grantor's #	Expenditures	
Federal Grantor	CFDA # Program Title		Cash	Noncash
<b><u>CABINET FOR HEALTH SERVICES (CONTINUED)</u></b>				
<b><u>U.S. Department of Health and Human Services</u></b>				
<b>Direct Programs: (Continued)</b>				
93.110	Maternal and Child Health Federal Consolidated Programs (Note 4)	N/A	\$ 198,565	
93.116	Project Grants and Cooperative Agreements for Tuberculosis Control Programs (Note 4) (Note 5)	N/A	965,540	\$ 77,962
93.119	Grants for Technical Assistance Activities Related to the Block Grant for Community Mental Health Services - Technical Assistance Centers for Evaluation (Note 4)	NA	66,149	
93.130	Primary Care Services - Resource Coordination and Development - Primary Care Offices (Note 4)	N/A	57,995	
93.136	Injury Prevention and Control Research and State and Community Based Programs (Note 4)	N/A	309,844	
93.150	Projects for Assistance In Transition from Homelessness (PATH) (Note 4)	N/A	299,999	
93.194	Community Prevention Coalitions (Partnership) Demonstration Grant (Note 4)	N/A	894,704	
93.217	Family Planning Services (Note 4)	N/A	4,145,747	
93.230	Consolidated Knowledge Development and Application (KD&A) Program (Note 4)	N/A	2,909,906	
93.234	Traumatic Brain Injury-State Demonstration Grant Program (Note 4)	N/A	47,967	
93.235	Abstinence Education (Note 4)	N/A	386,553	
93.238	Cooperative Agreements for State Treatment Outcomes and Performance Pilot Studies Enhancement (Note 4)	N/A	344,016	
93.241	State Rural Hospital Flexibility Program (Note 6)	N/A		
93.245	Innovative Food Safety Projects (Note 4)	N/A	45,000	
93.262	Occupational Safety and Health Research Grants (Note 4)	N/A	97,679	
93.268	Immunization Grants (Note 4) (Note 5)	N/A	2,745,545	7,780,634
93.283	Centers for Disease Control and Prevention - Investigations and Technical Assistance	N/A	893,246	
93.630	Developmental Disabilities Basic Support and Advocacy Grants (Note 4)	N/A	826,404	
93.767	State Children's Insurance Program	N/A	7,159,362	
93.777	State Survey and Certification of Health Care Providers and Suppliers (Note 2)	N/A	4,079,421	
93.778	Medical Assistance Program (Note 2)	N/A	2,260,846,947	
93.779	Health Care Financing Research, Demonstration, and Evaluations (Note 4)	N/A	385,913	
93.917	HIV Care Formula Grants (Note 4)	N/A	4,177,057	

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS  
FEDERAL ASSISTANCE PROGRAMS  
FOR THE YEAR ENDED JUNE 30, 2000**

State Agency Federal Grantor CFDA # Program Title		Pass Through Grantor's #	Expenditures CashNoncash	
<b><u>CABINET FOR HEALTH SERVICES (CONTINUED)</u></b>				
<b><u>U.S. Department of Health and Human Services</u></b>				
<b>Direct Programs: (Continued)</b>				
93.919	Cooperative Agreements for State-Based Comprehensive Breast and Cervical Cancer Early Detection Programs (Note 4) (Note 5)	N/A	\$ 1,532,688	\$ 125,000
93.931	Demonstration Grants to States for Community Scholarships (Note 4)	N/A	2,178	
93.940	HIV Prevention Activities - Health Department Based (Note 4) ( Note 5)	N/A	1,366,907	63,038
93.944	Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance	N/A	112,231	
93.945	Assistance Programs for Chronic Disease Prevention and Control	N/A	249,709	
93.958	Block Grants for Community Mental Health Services (Note 4)	N/A	3,442,990	
93.959	Block Grants for Prevention and Treatment of Substance Abuse (Note 2) (Note 4)	N/A	16,381,615	
93.977	Preventive Health Services - Sexually Transmitted Diseases Control Grants (Note 5)	N/A	784,103	178,902
93.988	Cooperative Agreements for State-Based Diabetes Control Programs and Evaluation of Serveillance Systems	N/A	264,332	
93.991	Preventive Health and Health Services Block Grant (Note 4)	N/A	2,403,192	
93.994	Maternal and Child Health Services Block Grant to the States (Note 4)	N/A	7,375,068	
<b>Passed Through From Cabinet for Families and Children:</b>				
93.556	Promoting Safe and Stable Families	N/A	9	
93.558	Temporary Assistance for Needy Families	N/A	1,936,685	
93.563	Chile Support Enforcement	N/A	41,157	
93.568	Low-Income Home Energy Assistance	N/A	625	
93.569	Community Services Block Grant	N/A	609	
93.575	Child Care and Development Fund (Note 6)	N/A		
93.595	Welfare Reform Research, Evaluations and National Studies	N/A	739,968	
93.658	Foster Care - Title IV - E	N/A	1,817	
93.667	Social Services Block Grant	N/A	1,174,000	
93.669	Child Abuse and Neglect State Grants	N/A	22	
93.671	Family Violence Prevention and Services/Grants for Battered Women's Shelters --Grants to States and Indian Tribes	N/A	135	
N/A	Clinical Laboratories Improvement Act	N/A	232,162	
<b><u>U.S. Corporation for National and Community Service</u></b>				
<b>Direct Program:</b>				
94.011	Foster Grandparent Program (Note 4)	N/A	471,716	
<b>Subtotal Cabinet for Health Services</b>			\$ 2,435,393,250	\$ 8,225,536

See accompanying notes to the Schedule of Expenditures of Federal Awards

**CABINET FOR HEALTH SERVICES  
NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS  
FOR THE YEAR ENDED JUNE 30, 2000**

**Note 1 - Purpose of the Schedule and Significant Accounting Policies**

**Purpose of the Schedule** - OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, requires a Schedule of Expenditures of Federal Awards showing each federal financial assistance program as identified in the Catalog of Federal Domestic Assistance.

**Basis of Presentation** - The accompanying schedule is presented in accordance with OMB Circular A-133. As defined in the circular, federal financial assistance “. . . means assistance that non-federal entities receive or administer in the form of grants, loans, loan guarantees, property (including donated surplus property), cooperative agreements, interest subsidies, insurance, food commodities, direct appropriations, and other assistance, but does not include amounts received as reimbursement for services rendered to individuals . . .” It includes awards received directly from federal agencies, or indirectly through other units of state and local governments. Accordingly, the accompanying schedule includes both cash and noncash federal financial assistance programs. Those programs that have not been assigned a catalog number, or for which the catalog number was not available, have been shown either at the bottom of the relevant federal grantor subheading or under the “Other Federal Assistance” subheading.

**Reporting Entity** - The accompanying schedule includes all federal financial assistance programs administered by CHS. CHS is an organizational unit of the Commonwealth of Kentucky as defined by KRS 12.010 and is included in the Commonwealth entity for financial reporting purposes.

**Basis of Accounting** - The cash expenditures on the accompanying schedule are presented primarily on the basis of cash disbursements as modified by the application of KRS 45.229. Consequently, certain expenditures are recorded in the accounts only when cash is disbursed.

KRS 45.229 provides that the Finance and Administration Cabinet may, “. . . for a period of thirty (30) days after the close of any fiscal year, draw warrants against the available balances of appropriations made for that fiscal year, for the payment of expenditures incurred during that year or in fulfillment of contracts properly made during the year, but for no other purpose.” However, there is an exception to the application of KRS 45.229 in that regular payroll expenses incurred during the last pay period of the fiscal year are charged to the next year.

**CABINET FOR HEALTH SERVICES  
NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**Note 1 - Purpose of the Schedule and Significant Accounting Policies (Continued)**

**Basis of Accounting (Continued)**

The Commonwealth's general-purpose financial statements are presented on the accrual/modified accrual basis of accounting. Therefore, the schedule's cash assistance programs may not be directly traceable to the general-purpose financial statements in all cases.

The noncash expenditures presented on this schedule represent the noncash assistance expended by CHS during the period July 1, 1999 through June 30, 2000, using the method or basis of valuation as described in the notes to the Schedule of Expenditures of Federal Awards for each program. These noncash assistance programs are not reported in CHS' general-purpose financial statements for the year ended June 30, 2000.

**Inter-agency Activity** -Certain transactions relating to federal financial assistance may appear in the records of more than one state agency. To avoid the overstatement of federal expenditures, the following policies were adopted for the presentation of CHS' schedule:

- (a) Federal moneys may be received by one state agency (primary state agency - recipient) and passed through to another state agency (secondary state agency - subrecipient) where the moneys are expended. Except for pass-throughs to state university or discussed below this inter-agency transfer activity is reported in the schedule as follows:
- Under the primary state agency, the federal program is reported as a direct program. However, the transfer of money to the secondary state agency is not included in the primary state agency's expenditures.
  - Under the secondary state agency, the federal program is reported as a pass-through program. The expenditure of the transferred moneys is reported in the secondary agency's expenditures.

Because the schedule excludes federal financial assistance related to state universities, when a state agency passes federal money to a state university, this is reported in the schedule as an expenditure of that state agency.

- (b) Federal moneys received by CHS and used to purchase goods or services from another state agency are reported in the schedule as an expenditure.

**CABINET FOR HEALTH SERVICES  
NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**Note 2 - Type A Programs**

Under the provisions of OMB Circular A-133, a Type A program for the Commonwealth means any program for which total expenditures of federal awards exceeds \$14 million for FY 2000. Clusters are a group of closely related programs sharing common compliance requirements. A cluster of programs shall be considered as one program for determining Type A programs.

CHS had three cash major programs that met the Type A major program definition for the year ended June 30, 2000. CHS identified one cluster, Medicaid, which included more than one federal program among the Type A programs. These Type A programs were:

<b>CFDA #</b>	<b>Program Title</b>	<b>Expenditures</b>
10.557	Special Supplemental Nutrition Program For Women, Infants, and Children	\$ 82,628,276
93.959	Block Grants For Prevention And Treatment Of Substance Abuse	16,381,615
<b>Medicaid Cluster</b>		
93.777	State Survey and Certification of Health Care Providers and Suppliers	4,079,421
93.778	Medical Assistance Program	2,260,846,947
<b>Total Type A Programs</b>		<u>\$ 2,363,936,259</u>

**Note 3 - Activity Occurring in Noncash Programs With Inventoriable Items**

CHS is a pass-through entity for local health departments and other providers. CHS received, stored, and distributed vaccine, needle, and syringe inventory items related to the Immunization Grants (CFDA #93.268) program through the fiscal year ending June 30, 2000.

No ending inventory balance could be presented because CHS did not maintain a perpetual inventory system and an accurate physical count was not taken at year-end. Because of this deficiency in agency records, the required note for the schedule could not be presented.

As a result of our comment last year, 98 CHS 42, pertaining to the inadequate inventory system, CHS has gone to a private distribution center to alleviate inventory problems. CHS' supply depot closed in November 2000 and all vaccines were shipped to a private company, Bellco, in New York. Starting January 1, 2001, all shipments originated with Bellco. See comment 98 CHS-42 in our Summary Schedule of Prior Year Audit Findings.

**CABINET FOR HEALTH SERVICES**  
**NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS**  
**FOR THE YEAR ENDED JUNE 30, 2000**  
**(CONTINUED)**

**Note 3 - Activity Occurring in Noncash Programs With Inventoriable Items**  
**(Continued)**

The basis of valuation for the noncash vaccine expenditures, as shown on the schedule, comes from the National Immunization Program Center for Disease Control's Orders Approved Report.

**Note 4 - Subrecipient Activity**

A subrecipient is a non-federal entity that expends federal awards received from a pass-through entity to carry out a federal program. The following list summarizes the amount of federal funds sent to subrecipients.

<b>CFDA #</b>	<b>Federal Program Name</b>	<b>Amount Sent</b>
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children	\$ 1,099,712
10.570	Nutrition Program for the Elderly (Commodities)	1,813,041
17.235	Senior Community Services Employment Program	1,529,619
66.032	State Indoor Radon Grants	63,368
81.502	Paducah Gaseous Diffusion Plant Environmental Monitoring and Oversight	254,252
83.549	Chemical Stockpile Emergency Preparedness Program	72,384
84.181	Special Education – Grants for Infants and Families with Disabilities	1,095,626
84.186	Safe and Drug-Free Schools and Communities - State Grants	1,390,755
84.323	Special Education-State Program Improvement Grants for Children with Disabilities	\$ 6,000
93.041	Special Programs for the Aging – Title VII Chapter 3 – Programs for Prevention of Elder Abuse, Neglect, and Exploitation	63,653
93.042	Special Programs for the Aging, Title VII, Chapter 2, - Long-term Care Ombudsman Services for Older Individuals	42,842
93.043	Special Programs for the Aging – Title III, Part F – Disease Preventive and Health Promotion Services	192,936
93.044	Special Programs for the Aging – Title III, Part B – Grants for Supportive Services and Senior Centers	4,466,099
93.045	Special Programs for the Aging – Title III, Part C – Nutrition Services	6,684,753

**CABINET FOR HEALTH SERVICES**  
**NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS**  
**FOR THE YEAR ENDED JUNE 30, 2000**  
**(CONTINUED)**

**Note 4 - Subrecipient Activity (Continued)**

<b>CFDA #</b>	<b>Federal Program Name</b>	<b>Amount Sent</b>
93.046	Special Programs for the Aging – Title III, Part D – In-Home Services for Frail Older Individuals	96,374
93.048	Special Programs for the Aging – Title IV – Training, Research, and Discretionary Projects and Programs	84,599
93.110	Maternal and Child Health Federal Consolidated Programs	146,203
93.116	Project Grants and Cooperative Agreements For Tuberculosis Control Programs	21,000
93.119	Grants for Technical Assistance Activities Related to the Block Grant for Community Mental Health Services – Technical Assistance Centers for Evaluation	63,149
93.130	Primary Care Services – Resource Coordination and Development - Primary Care Offices	26,000
93.136	Injury Prevention and Control Research and State and Community Based Programs	309,844
93.150	Projects for Assistance in Transition from Homelessness (PATH)	299,999
93.194	Community Prevention Coalitions (Partnership) Demonstration Grant	145,147
93.217	Family Planning Services	23,000
93.230	Consolidated Knowledge Development and Application (KD&A) Program	2,694,738
93.234	Traumatic Brain Injury-State Demonstration Grant Program	\$ 47,967
93.235	Abstinence Education	5,000
93.238	Cooperative Agreements for State Treatment Outcomes and Performance Pilot Studies Enhancement	321,830
93.245	Innovative Food Safety Projects	45,000
93.262	Occupational Safety and Health Research Grants	103,278
93.268	Immunization Grants	484,158
93.630	Developmental Disabilities Basic Support and Advocacy Grants	103,474
93.778	Medical Assistance Program	458,980
93.779	Health Care Financing Research, Demonstration, and Evaluations	312,606

**CABINET FOR HEALTH SERVICES**  
**NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS**  
**FOR THE YEAR ENDED JUNE 30, 2000**  
**(CONTINUED)**

**Note 4 - Subrecipient Activity (Continued)**

<b>CFDA #</b>	<b>Federal Program Name</b>	<b>Amount Sent</b>
93.917	HIV Care Formula Grants	125,711
93.919	Cooperative Agreements for State-Based Comprehensive Breast and Cervical Cancer Early Detection Programs	338,127
93.931	Demonstration Grants to States for Community Scholarships	2,178
93.940	HIV Prevention Activities-Health Department Based	1,138,262
93.945	Assistance Programs for Chronic Disease Prevention and Control	450,000
93.958	Block Grants for Community Mental Health Services	3,194,043
93.959	Block Grants for Prevention and Treatment of Substance Abuse	14,976,157
93.991	Preventive Health and Health Services Block Grant	707,848
93.994	Maternal and Child Health Services Block Grant to the States	4,157,304
94.011	Foster Grandparents Program	54,239
<b><u>Total Amounts Sent To Subrecipients</u></b>		<b><u>\$49,711,255</u></b>



**CABINET FOR HEALTH SERVICES**  
**NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS**  
**FOR THE YEAR ENDED JUNE 30, 2000**  
**(CONTINUED)**

**Note 5 - Noncash Expenditure Programs**

CHS had five (5) noncash programs for the year ended June 30, 2000. These noncash programs and a description of the method/basis of valuation follow:

<b>CFDA #</b>	<b>Program Title</b>	<b>Amount</b>	<b>Method/Basis of Valuation</b>
93.116	Project Grants and Cooperative Agreements for Tuberculosis Control Programs	\$ 77,962	Per authorized award for personnel costs and travel.
93.268	Immunization Grants	7,780,634	Per authorized award for personnel and vaccine costs.
93.919	Cooperative Agreements for State-Based Comprehensive Breast and Cervical Cancer Early Detection Programs	125,000	Per authorized personnel and other costs and travel.
93.940	HIV Prevention Activities – Health Department Based	63,038	Per authorized personnel and other costs.
93.977	Preventive Health Services – Sexually Transmitted Diseases Control Grants	178,902	Per authorized personnel costs and travel.
<b>Total</b>		<u>\$ 8,225,536</u>	

**Note 6 - Zero Expenditure Programs**

These programs had no expenditures during the year ended June 30, 2000. They include programs with no activity during the year, such as old programs not officially closed out or new programs issued late in the fiscal year. They also included programs with activity other than expenditures.

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**REPORTS ON COMPLIANCE AND ON INTERNAL CONTROL**





EDWARD B. HATCHETT, JR.  
AUDITOR OF PUBLIC ACCOUNTS

To the People of Kentucky  
Honorable Paul E. Patton, Governor  
Marcia Morgan, Secretary  
Cabinet for Health Services

Report On Compliance And On Internal Control Over  
Financial Reporting Based On An Audit Of The General-Purpose Financial  
Statements Performed In Accordance With *Government Auditing Standards*

As part of the audit of the general-purpose financial statements of the Commonwealth of Kentucky as of and for the year ended June 30, 2000, we have audited receipts, expenditures, payroll, accounts receivable, accounts payable, and judgments and contingencies of the Cabinet for Health Services (CHS), an organizational unit of the Commonwealth as defined by KRS 12.010, and have issued our report thereon dated February 28, 2001. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Compliance

As part of obtaining reasonable assurance about whether the Commonwealth's financial statements are free of material misstatement, we performed tests of CHS' compliance with certain provisions of laws, regulations, contracts, and grants, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

Report On Compliance And On Internal Control Over  
Financial Reporting Based On An Audit Of The General-Purpose  
Financial Statements Performed In Accordance With *Government Auditing Standards*  
(Continued)

Internal Control Over Financial Reporting

In planning and performing our audit, we considered CHS' internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be material weaknesses. A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted no matters involving the internal control over financial reporting and its operation that we consider to be material weaknesses. However, we noted other matters involving the internal control over financial reporting, which we have reported in the accompanying schedule of findings and questioned costs as items 00-CHS-1, 00-CHS-2 and 00-CHS-3.

This report is intended solely for the information and use of management and federal awarding agencies and pass-through entities and is not intended to be, and should not be, used by anyone other than these specified parties.

Respectfully submitted,



Edward B. Hatchett, Jr.  
Auditor of Public Accounts

February 28, 2001



EDWARD B. HATCHETT, JR.  
AUDITOR OF PUBLIC ACCOUNTS

To the People of Kentucky  
Honorable Paul E. Patton, Governor  
Marcia Morgan, Secretary  
Cabinet for Health Services

Report On Compliance With Requirements Applicable To Each  
Major Program And On Internal Control Over Compliance In Accordance  
With OMB Circular A-133 And On The Schedule Of Expenditures Of Federal Awards

Compliance

As part of the Statewide Single Audit of the Commonwealth of Kentucky, we have audited the compliance of the Cabinet for Health Services (CHS), an organizational unit of the Commonwealth of Kentucky as defined by KRS 12.010, with the types of compliance requirements described in the *U.S. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement* that are applicable to each of its major federal programs for the year ended June 30, 2000. CHS' major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs. Compliance with the requirements of laws, regulations, contracts, and grants applicable to each of its major federal programs is the responsibility of CHS' management. Our responsibility is to express an opinion on CHS' compliance based on our audit.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about CHS' compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination on CHS' compliance with those requirements.

In our opinion, CHS complied, in all material respects, with the requirements referred to above that are applicable to each of its major federal programs for the year ended June 30, 2000.

Report On Compliance With Requirements Applicable To Each  
Major Program And On Internal Control Over Compliance In Accordance  
With OMB Circular A-133 And On The Schedule Of Expenditures Of Federal Awards  
(Continued)

Internal Control Over Compliance

Management of CHS is responsible for establishing and maintaining effective internal control over compliance with requirements of laws, regulations, contracts, and grants applicable to federal programs. In planning and performing our audit, we considered CHS' internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133.

We noted certain matters involving the internal control over compliance and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over compliance that, in our judgment, could adversely affect CHS' ability to administer a major federal program in accordance with applicable requirements of laws, regulations, contracts, and grants. The reportable conditions are described in the accompanying schedule of findings and questioned costs as items 00-CHS-4, 00-CHS-5, 00-CHS-6, 00-CHS-7, 00-CHS-8, and 00-CHS-9.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that noncompliance with the applicable requirements of laws, regulations, contracts, and grants that would be material in relation to a major federal program being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over compliance would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, we believe that the reportable conditions described above are not material weaknesses.

We also noted other matters involving the internal control over compliance that we have reported to the management of CHS and described in the accompanying schedule of findings and questioned costs.

Schedule of Expenditures of Federal Awards

We have audited the general-purpose financial statements of the Commonwealth as of and for the year ended June 30, 2000, and have issued our report thereon dated February 28, 2001. Our audit was performed for the purpose of forming an opinion on the general-purpose financial statements taken as a whole. The accompanying schedule of expenditures of federal awards of CHS is presented for the analysis as required by OMB Circular A-133 and is not a required part of the general-purpose financial statements. Such information has been subjected to the auditing procedures applied in the audit of the general-purpose financial statements.



Report On Compliance With Requirements Applicable To Each  
Major Program And On Internal Control Over Compliance In Accordance  
With OMB Circular A-133 And On The Schedule Of Expenditures Of Federal Awards  
(Continued)

Schedule of Expenditures of Federal Awards (Continued)

As described in Note 1, the schedule of expenditures of federal awards of CHS is intended to present only that portion of the expenditures of federal awards of the Commonwealth that is attributable to the transactions of CHS.

The general-purpose financial statements of the Commonwealth are prepared on the accrual/modified accrual basis of accounting. However, as described in Note 1, the schedule of expenditures of federal awards of CHS is prepared on the basis of cash disbursements as modified by the application of KRS 45.229. Consequently, certain expenditures are recorded in the accounts only when cash is disbursed. Accordingly, the schedule of expenditures of federal awards is not intended to present the expenditures of federal awards in conformity with accounting principles generally accepted in the United States of America.

In our opinion, except for the effect of the application of a different basis of accounting as explained above, the schedule of expenditures of federal awards of CHS is fairly stated, in all material respects, in relation to the Commonwealth's general-purpose financial statements taken as a whole.

This report is intended solely for the information and use of management and federal awarding agencies and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

Respectfully submitted,



Edward B. Hatchett, Jr.  
Auditor of Public Accounts

Schedule of Expenditures of Federal Awards -  
February 28, 2001

July 27, 2001



**SCHEDULE OF FINDINGS AND QUESTIONED COSTS**



**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000**

**SECTION 1 - SUMMARY OF AUDITOR'S RESULTS**

**Financial Statement Accounts**

Financial Statement Accounts: We issued an unqualified opinion on the Commonwealth's general-purpose financial statements, which included the Cabinet for Health Services (CHS), as of and for the year ended June 30, 2000.

Internal Control Over Financial Reporting: Our consideration of CHS' internal control over financial reporting disclosed no reportable conditions. However, we noted other matters that we have reported in the Schedule of Findings and Questioned Costs.

Compliance: The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

**Federal Awards And Schedule OF Expenditures Of Federal Awards**

Compliance: We issued an unqualified opinion on CHS' compliance with the requirements applicable to each of its major federal programs.

Internal Control Over Compliance: Our consideration of CHS' internal control over compliance disclosed six reportable conditions. We believe that none of the reportable conditions noted are material weaknesses.

Additionally, our audit disclosed five comments that we consider other matter comments that relate to internal control over major programs. We reported this to CHS management.

Schedule of Expenditures of Federal Awards: We issued a qualified opinion on CHS' Schedule of Expenditures of Federal Awards because the schedule was presented on a basis of accounting that was not in conformance with accounting principles generally accepted in the United States of America. As described in Note 1 of the schedule, the opinion was issued in relation to the Commonwealth's general-purpose financial statements taken as a whole.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTNUED)**

**SECTION 1 - SUMMARY OF AUDITOR'S RESULTS (Continued)**

**Identification of Major Programs Audited**

OMB Circular A-133 defines a major program as "a Federal program determined by the auditor to be a major program in accordance with section \_\_.520 or a program identified as a major program by the Federal awarding agency or pass-through entity in accordance with section \_\_.215(c)." Section \_\_.520 states, "The auditor shall use a risk-based approach to determine which Federal programs are major programs." The following is a list of major Type A programs audited:

<b>CFDA #</b>	<b>Program Title</b>	<b>Expenditures</b>
10.557	Special Supplemental Nutrition Program For Women, Infants, and Children	\$ 82,628,276
93.959	Block Grants For Prevention And Treatment Of Substance Abuse	16,381,615
<b>MEDICAID CLUSTER</b>		
93.777	State Survey and Certification of Health Care Providers and Suppliers	4,079,421
93.778	Medical Assistance Program	<u>2,260,846,947</u>
	Total Type A Programs	<u>\$ 2,363,936,259</u>

**Dollar Threshold Used to Distinguish Between Type A and Type B Programs**

The maximum dollar threshold used to distinguish between Type A and Type B Programs was \$14,000,000. No Type B programs were audited in FY 2000.

**Auditee Qualify as Low-Risk Auditee?**

The Commonwealth did not qualify as a low-risk auditee.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 2 - FINANCIAL STATEMENT FINDINGS**

**Other Matter Comments Relating To Internal Control And/Or Compliance:**

**FINDING 00-CHS-1: The Cabinet For Health Services Should Improve Control Procedures Over The Medicaid Assistance Program**

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UNISYS adjudicates claims for the Medicaid Expenditures. During our audit period, CHS' Department for Medicaid Services (DMS) performed a review called Contract Monitoring Sample to ensure proper claims processing. DMS's sample selection method used a starting number with skip intervals that is changed monthly according to the claim volume to select the samples within each of the categories (e.g., Hospital Services, Long-Term Care Services, etc.). The total claims selected for testing was far below the final number of the claim universe. This selection method resulted in approximately 30% of the population having no opportunity of being selected. Additionally, UNISYS selected the sample of claims to test. DMS did not perform a reconciliation of the population to ensure that the sample was pulled from the entire population of adjudicated claims.

This has been a comment the past three years. However, it should be noted that corrective measures were taken in the latter part of FY 2000. Therefore, the auditor believes the weakness has been corrected.

Good internal controls dictate that information received from outside sources be verified for completeness and accuracy. In addition, Part II of the State Medicaid Manual, Chapter 6, states, "[t]he sample selection must be performed on a complete sampling frame. A sampling frame for the prescribed sample universe is all Medicaid line items authorized for payment."

**Recommendation**

We recommend DMS continue to use the corrective measures that were in place during the latter part of FY 2000 so that all claims are included in the universe and have an equal chance of being reviewed. In addition, to be sure that the sample was pulled from the entire population of adjudicated claims, a reconciliation should be performed.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 2 - FINANCIAL STATEMENT FINDINGS**

**Other Matter Comments Relating To Internal Control And/Or Compliance:**  
**(Continued)**

**FINDING 00-CHS-1: The Cabinet For Health Services Should Improve Control Procedures Over The Medicaid Assistance Program (Continued)**

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**Management's Response and Corrective Action Plan**

*The Department for Medicaid Services (DMS) concurs with the Recommendation for Improvement and will continue to use the corrective measures that were in place during the latter part of FY 2000 so that all claims are included in the universe and have an equal chance of being reviewed. A reconciliation will be performed to ensure that all claims are included in the universe.*

*DMS concurs with the auditor that this weakness has been corrected.*

**FINDING 00-CHS-2: The Cabinet For Health Services Should Improve Controls Over The Review/Monitoring Process**

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During FY 2000, UNISYS was contracted by the DMS for provider enrollment functions within the Medicaid program. With the creation of the contract, it is the responsibility of the Program Integrity and Utilization Review Branch to monitor the provider enrollment functions. The provider enrollment monitoring process was reviewed by the auditor during the FY 2000 audit. It appears that controls are in place to monitor the functions that have been contracted out to UNISYS. However, there is a slight weakness in the controls. It was noted that the randomly chosen sample that is reviewed each month is not being documented in the form of a log. In addition, the re-enrollees that have been expired for less than 12 months are not being reviewed in a timely manner. These documents are received by DMS approximately every other week. It was noted during testing that these documents are not always reviewed in a timely manner.

Provider enrollment information could be incorrect/incomplete; therefore, possibly causing the provider to not be eligible to receive reimbursement for Medicaid services.

Good internal control dictates that documentation of a review/monitoring process of a contracted agent be kept. In addition, the review/monitoring process should be performed within a timely manner.



**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 2 - FINANCIAL STATEMENT FINDINGS**

**Other Matter Comments Relating To Internal Control And/Or Compliance:**  
**(Continued)**

**FINDING 00-CHS-2: The Cabinet For Health Services Should Improve Controls Over The Review/Monitoring Process (Continued)**

---

**Recommendation**

We recommend that DMS:

- Keep a log of the providers reviewed during the monitoring of provider enrollment functions that have been contracted out to UNISYS. The log should include the provider number, name of the provider, date reviewed, and a comment (i.e., if there was a problem or not). If there was a problem found during the review, the log should include information of what was done to correct it and when it was followed up on to ensure the correction was made.
- Review the provider enrollment functions that have been contracted out to UNISYS within a timely manner. For new enrollees and re-enrollees that have been expired over 12 months, the review should be done within one week of the first working day of the month. For re-enrollees that have been expired for less than 12 months, the review should be done within one week from when the information is received from UNISYS.

**Management's Response and Corrective Action Plan**

*The Provider Enrollment staff currently have two database logs to keep track of providers as they are reviewed during the monitoring of provider enrollment functions. The New Enrollee Monitoring database currently provides space to input: Name, Organization Type, Provider Number, Last Transaction Date, Date Reviewed, Master Display, Electronic Funds, Billing/FYE, Address, Provider G Group, Bed Data, PP File, Ownership, CLIA, Comments, and Action Taken. The Update Enrollment Monitoring database currently provides space to input: Name, Provider Number, Date Reviewed, Comments, and Action Taken. The use of these databases ensures that we are able to keep track of the newly enrolled providers as well as the previously enrolled providers. It also gives us a log to track any problems that Unisys may be having to report to the report card, as well as all actions taken by this office and Unisys to correct these problems.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 2 - FINANCIAL STATEMENT FINDINGS**

**Other Matter Comments Relating To Internal Control And/Or Compliance:**  
(Continued)

**FINDING 00-CHS-2: The Cabinet For Health Services Should Improve Controls Over The Review/Monitoring Process (Continued)**

**Management's Response and Corrective Action Plan (Continued)**

*At the beginning of each month UNISYS runs a report to identify medical providers newly enrobed in the Medicaid program. From that list, random samples of 25 to 50 provider files are pulled to be used in the monitoring process. The information retrieved from the providers' enrollment forms is entered into a database that is used to determine if Unisys entered the application correctly into the GUI system. Further, a box of correspondence is sent to the Program Integrity Branch on a weekly basis. Each week Provider Enrollment staff randomly selects 25 to 50 documents from the box of correspondence to ensure all changes and updates have been entered properly on the GUI system.*

*Implementation date: January 3, 2001*

**FINDING 00-CHS-3: The Cabinet For Health Services Should Strengthen Controls Over Cash Receipts**

During the course of our audit of the receipts in the Department of Vital Statistics, we noted two control weaknesses:

- 1) On three separate occasions, when in the department to observe the work and be introduced to the employees, cash was observed to be paper clipped to a pen and pencil holder on top of the desk.
- 2) The cash register is placed in a high-traffic walkway. Although the department has begun to remodel, this placement of the cash register is a concern due to the traffic in the area.

Cash is laid out in the open where it can be misplaced or stolen. Also, the placement of the cash register needs to be reconsidered during renovation so that it is not in a main walkway where cash can be easily removed from the drawer. Both of these occurrences provide the opportunity for cash being misplaced or stolen.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 2 - FINANCIAL STATEMENT FINDINGS**

**Other Matter Comments Relating To Internal Control And/Or Compliance:**  
**(Continued)**

**FINDING 00-CHS-3: The Cabinet For Health Services Should Strengthen Controls Over Cash Receipts (Continued)**

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Proper internal control should be maintained over cash in the Department of Vital Statistics in order for the agency to safeguard its assets. Cash should be placed in a locked container, a lockable cash bag, and/or a locked desk drawer until such time that it can be secured in a safe.

**Recommendation**

We recommend the Department of Vital Statistics make the following changes:

- 1) The Custodian over cash transactions should ensure that cash is placed in a secure location.
- 2) The cash register should be located in a more secure area where reduced traffic will limit the possibility of cash being lost or stolen.

**Management's Response and Corrective Action Plan**

*Cash is now placed in a bank deposit bag and put in the desk drawer until the end of the day when it is placed in the safe.*

*The cash register has temporarily been placed in a corner behind the customer service desk. The Vital Statistics Office is presently being renovated, after the renovation is completed, February or March 2001, the register will be placed behind the customer service desk in a manner in which only the employees working the service desk will have access.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance:**

**FINDING 00-CHS-4: The Division of Substance Abuse Should Conduct Peer Reviews As Required By Federal Regulations**

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State Agency: Cabinet for Health Services

Federal Program: CFDA 93.959 - Block Grants for Prevention and Treatment of Substance Abuse

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Entity: Not Applicable

Compliance Area: Special Tests and Provisions

Amount of Questioned Costs: None

The Division of Substance Abuse (SA) in the Department for Mental Health and Mental Retardation (DMH/MR) purposely did not conduct peer reviews during FY 2000. SA reported this deficiency in their application for funding to the federal government. They also reported that peer reviews would be reinstituted in FY 2001.

Peer reviews were not performed in FY 2000 because the DMH/MR was in the process of revamping its contract requirements to develop an outcome-related, performance-based funding system. DMH/MR also wanted to establish related monitoring protocols that fully utilize automated data and other reported information.

Without peer reviews, SA cannot monitor subrecipients properly and is not in compliance with 45 CFR 96.136. Peer review provides an independent, on-site review of Community Mental Health Centers (CMHC) to ensure block grant moneys are expended according to laws and regulations. It also gives monitoring staff performance measurements about the delivery systems of substance abuse services. Thus, monitoring staff is at a disadvantage when conducting on-site reviews.

According to 45 CFR 96.136, the state must provide for independent peer reviews that assesses the quality, appropriateness, and effectiveness of treatment services provided to individuals. At least five percent of the entities providing services in the state shall be reviewed.

**Recommendation**

We recommend peer reviews be reinstituted in FY 2001 as planned by SA. The peer reviews should meet the requirements of 45 CFR 96.136 and include, at least, five percent of the entities providing services in the state. We further recommend planned protocol be used, which at least addresses the six areas required by 45 CFR 96.136.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-4: The Division Of Substance Abuse Should Conduct Peer Reviews As Required By Federal Regulations (Continued)**

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**Management's Response and Corrective Action Plan**

*Peer reviews were re-instituted in State Fiscal Year 2001 and conducted on a five percent (5%) sample of Substance Abuse Prevention and Treatment funded programs. Sample programs will include detoxification, residential, outpatient and programs offering case management services to targeted populations.*

*In State Fiscal Year 1998, state staff in consultation with the peer reviewers prepared a review protocol. The protocol was also developed in conjunction with the State Substance Abuse Medical Director. The protocol addresses the six (6) areas referenced in 45 CFR 96.136.*

*In addition to these six (6) domains, peer reviews in State Fiscal Year 2001 plan to focus on performance measures such as penetration rates of targeted populations (e.g., pregnant women, women with dependent children, intravenous drug users, TANF referrals, persons referred through child protective services and criminal justice referrals). In addition, persons participating in the Department Treatment Outcome Study (KTOS) will be targeted as a performance measure for contracted funds.*

*Peer reviewers are selected from the fourteen (14) Regional Alcohol and Drug program Directors and persons with previous peer review experience. Independent peer reviewers are individuals with expertise in the field of alcohol and drug treatment and prevention. Reviewers must be knowledgeable about the modality being reviewed and its underlying theoretical approach to addiction treatment and must be sensitive to the cultural and environmental issues that may influence the quality of the services provided.*

*Volunteers will be matched with state staff based on geography (proximity), programmatic expertise, reviewer interest, and availability. No reviewer is allowed to review his or her own agency.*

*FFY 2001 reviews are currently being conducted in conjunction with the Department's annual monitoring visits.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-5: The Department For Medicaid Services Should Improve Claims Processing, Including The Dispute-Resolution Process With Drug Rebate Manufacturers**

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State Agency: Cabinet for Health Services

Federal Program: CFDA: 93.778 - Medical Assistance Program

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Entity: Not Applicable

Compliance Area: Special Tests and Provisions

Amount of Questioned Costs: None

Section 4401 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 requires drug manufacturers to enter and have in effect a rebate agreement with the federal government for states to receive funding for drugs dispensed to Medicaid recipients. Under the agreement, manufacturers must rebate a portion of the price received from the sale of drugs, which were paid by Medicaid. The amount of the rebate per unit for each drug from a manufacturer is determined by the Health Care Financing Administration (HCFA) and is supplied to states on a quarterly basis.

During our testing of internal controls over the Drug Rebate Program, we noted several weaknesses in various areas. We tested 51 Rebate Billing Statements for accuracy, timeliness, and proper recording. We tested these billings statements from the billing cycle through the receipt cycle.

The exceptions to our testing are noted below:

1. Twenty-two receipts were not posted to the manufacturer's account in a timely manner. Our criteria for testing this procedure was a five-day period to post the receipt of drug rebate checks from the date received by the fiscal agent (UNISYS). We believe five days to be a reasonable amount of time to perform this particular procedure. However, according to the agency policy established by the Department of Medicaid Services (DMS), the time frame for posting this information is by the 10<sup>th</sup> day of the following month. Thus, a check received by the fiscal agent on the first day of the month could, theoretically, remain unposted for 40 days prior to being posted in the Labeler Detail screen, which summarizes quarterly activity for the drug manufacturer. Alternatively, a check received on the last day of the month is required to be posted in 10 days. Therefore, posting requirements range from 10-40 days. This large gap of time for posting is difficult to understand. Our review indicated that, on average, about 10-15 rebate checks were received per day. In our opinion, posting this information should not take 40 days.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-5: The Department For Medicaid Services Should Improve Claims Processing, Including The Dispute-Resolution Process With Drug Rebate Manufacturers (Continued)**

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During this time frame, the checks that are received by UNISYS from the drug manufacturer are forwarded to Fiscal Services, where they are deposited in a timely manner. Therefore, it does not seem logical that the posting procedure should, in some circumstances, take an unreasonable amount of time to be posted into the system. While the agency has apparently given consideration to this policy, this procedure is not adequate in our opinion.

2. Seventeen rebates were not received by their due date. Our criteria for determining this exception was based on a 38-day requirement for making payment. This time frame is established on each bill sent to the drug manufacturer and stipulates, “[p]ayment is due 38 days after the stamped postage date.” Of the 17 rebates deemed late under the 38-day criteria, 6 rebates were not received within 60 days of the billing. According to agency policy, a delinquent notice is sent to each drug manufacturer after 60 days. However, in most cases, we determined that a partial payment from the manufacturer was eventually received, rather than not receiving any payment from the drug manufacturer. Thus, in several cases, the entire amount of the rebate received does not agree to the amount billed, which creates the problem of unresolved balances. These unresolved balances are placed in a dispute resolution file.
3. The testing results of late posting of receipts noted above were investigated and discussed with agency personnel. We learned that the state has \$79 million of unresolved manufacturer billings as a result of having no resolution process in place.

Since the implementation of the Drug Rebate Program in 1991, DMS has made great strides in developing and implementing controls over the program. However, we are still concerned with outstanding drug rebate balances that remain unresolved. In some instances, unresolved cases are 10 years old. We are aware of the fact that on March 1, 1997 DMS hired the services of an outside vendor, ClaimTraq, Inc., to assist DMS with the resolution of these outstanding labeler balances for the period 1991 through 1997 -- some of which may date back to the inception of the program. This contract ended on June 30, 1999.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-5: The Department For Medicaid Services Should Improve Claims Processing, Including The Dispute-Resolution Process With Drug Rebate Manufacturers (Continued)**

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On July 1, 1999, a contract was entered into between First Health Services Corporation and DMS for First Health to assist DMS with the resolution of outstanding labeler balances for the period January 1997 through January 1998. Unfortunately, during FY 2000, resolution of outstanding drug rebate balances was inconsistently applied; thus, we cannot confirm that controls were in place and operating for the resolution of outstanding drug labeler balances. In fact, no disputed rebates were collected for this time frame.

4. Apparently, there is no federal requirement that outstanding accounts receivable balances be written off as uncollectable in the Drug Rebate Program. As discussed above, the outstanding accounts receivable balance at June 30, 2000 was \$79 million.

The lack of an effective internal control structure increases the risk that laws and regulations of the Drug Rebate Program will not be followed, leading to the possibility of sanctions by the federal government, including possible disallowance of expenditures. Furthermore, since a portion of the rebate collected would be used to reimburse the Commonwealth for its match, failure to collect all rebates due could result in a significant loss of state revenue.

The Drug Rebate Program was established within the Medicaid Assistance Program (MAP) by federal law to recover from drug manufacturers a fee per drug unit dispensed by providers of Medicaid services. It is DMS's responsibility to establish internal controls to properly record, collect, and report all amounts owed to and received by MAP.

**Recommendation**

We recommend proper controls be implemented by the fiscal agent or by DMS to ensure the following objectives are met:

1. All labeler checks received should be posted to the drug manufacturer's account in the Medical Management Information System (MMIS) in a reasonable time frame. In addition, we recommend the agency reconsider the policy for posting the rebate checks. In its current state, the policy could allow up to 6 weeks to post checks or, at a minimum, 10 days would be required to post those checks. A reasonable time period would be 5-10 days, not a 6-week period.



**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-5: The Department For Medicaid Services Should Improve Claims Processing, Including The Dispute-Resolution Process With Drug Rebate Manufacturers (Continued)**

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**Recommendation (Continued)**

2. Drug Rebate discrepancies, such as outstanding balances, between DMS and drug labelers be resolved within a reasonable amount of time. We are aware HCFA has developed a “*Best Practices for States - Best Practices for Dispute Resolution*,” which outlines ways states can avoid unnecessary disputes. This guide also provides a ten-step process for resolving drug rebate disputes and has been implemented in several surrounding states’ Medicaid programs. However, Kentucky’s Medicaid program has not adopted these procedures. We recommend that DMS consider adopting these “best practices.” At least this would be a good starting point for the resolution of the \$79 million unresolved balance.
3. The creation of a better dispute resolution process should significantly decrease the amount of long-term accounts receivable balances. HCFA’s “best practices” require a resolution to all disputes. Thus, the manufacturer should make payment, or the account should reach some resolution, such that disputed receivables would be written off the books. Procedures should be considered for writing off outstanding accounts receivable balances.

**Management’s Response and Corrective Action Plan**

1. *The Department has reviewed the audit findings and agrees with the recommendation of the Auditors. Effective September 1, 2001, the Department will require that labeler checks be posted within ten days of receipt.*
2. *HCFA indicates in the Foreword to “Best Practice for Dispute Resolution under the Medicaid Drug Rebate Program” that the booklet “is a compilation of information based on our (HCFA) experiences and lessons learned through the Drug Rebate Program (DRP) and is intended to be a valuable resource for all participants in the program”. There are ten “Best Practices for States” identified by HCFA.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-5: The Department For Medicaid Services Should Improve Claims Processing, Including The Dispute-Resolution Process With Drug Rebate Manufacturers (Continued)**

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**Management's Response and Corrective Action Plan (Continued)**

*They Are:*

- 1. Review receivables to determine correct balances, including records of payments, invoices, etc. States should schedule time to do a thorough review of a Manufacturer's accounts prior to beginning to work on resolving disputes.*
- 2. Scheduling/Prioritizing/Resources Agreement. States should place a priority on resolving the oldest outstanding quarters as soon as possible. States should move to resolve the largest outstanding dollar amounts before dealing with some of the smaller dollar amounts.*
- 3. State and Manufacturer should both commit to a process that leads to a resolution. States and Manufacturers should jointly develop and individually commit to a strategy that will lead to a resolution in a timely manner. Each Manufacturer is different therefore strategy will differ by labeler.*
- 4. Reconcile balances due to accounting/bookkeeping differences.*
- 5. States should work with Manufacturers to reconcile balances and disputes arising due to questions about utilization data. The most important thing that the State should do upon receiving notice from the Manufacturer that they are disputing is to understand the reason for the dispute.*
- 6. Agree to necessary unit adjustments from utilization/dispute discussion and document appropriately. Any proposal the State makes with respect to making adjustments to the Manufacturer's balance should be documented. Finalized resolutions should be documented as well and should be included as part of the drug rebate file.*
- 7. Agree upon "corrected" units and rates should be compared to records again to determine final dollar balances due for resolution*
- 8. Complete resolution acknowledgement (resolution letter). Once the State and Manufacturer have reached an agreement on the steps each party will take to resolve the dispute, the agreement should be documented.*
- 9. Monitor timely receipt of final resolution.*
- 10. Post resolution payments and document resolution closure. Once both parties have reached agreement and are able to post a zero balance, that agreement should be documented and maintained in both entities' files.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-5: The Department For Medicaid Services Should Improve Claims Processing, Including The Dispute-Resolution Process With Drug Rebate Manufacturers (Continued)**

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**Management's Response and Corrective Action Plan (Continued)**

*The Department does currently follow six of the ten "Best Practices" and will consider if the remaining four improve the process enough to be implemented.*

*The \$79 million referred to is the ending balance of the total in outstanding invoices from the beginning of the Pharmacy Rebate Program in June 1991 to June 30, 2000. In state fiscal year ended June 30, 2000, the Department invoiced Manufacturers for a total of \$86 million. Of this amount invoiced in fiscal 2000, the Department received \$67 million, or 78% of the amount invoiced. Of the \$79 million ending balance as of June 30, 2000, \$19 million applies to amounts invoiced in fiscal 2000. Earlier periods are in dispute. The Department has contracted with an outside contractor with expertise in the Pharmacy Rebate Program to assist in the dispute resolution process.*

*During the December 31, 2000 quarter, \$58 million was entered as an adjustment to the September 30, 1992 and the December 31, 1992 quarters.*

*During the December 31, 2000 quarter, the amounts were reversed. Elimination of this adjustment from the \$79 million balance shown, at June 30, 2000 will change the June 30, 2000 balance to \$21 million, or \$2 million from prior fiscal years.*

3. *The HCFA "best practices" guideline indicates that a State may establish a threshold of \$50 per labeler per quarter for States to opt not to send or pursue invoice collection. The Department is awaiting a decision from HCFA on the possibility of the threshold being increased from the \$50 per labeler level and including the age of the account receivable. If the State adopts a threshold, HCFA does require the State to maintain documentation identifying the quarter, the labeler, the NDC's, the units involved and the amount involved.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-5: The Department For Medicaid Services Should Improve Claims Processing, Including The Dispute-Resolution Process With Drug Rebate Manufacturers (Continued)**

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**Auditor's Reply**

At the time of this printing, CHS could not adequately explain the origin of the \$58 million adjustment or the reason therefore. We are also concerned with the lack of a resolution process that will eliminate carrying such large balances for long periods of time. Although the agency indicates a substantial reduction in the unresolved balances subsequent to our audit period, we would suggest that the agency vigorously seek methods to resolve these disputes and further reduce this unresolved balance. We further suggest that the agency implement all of the suggested policies consistent with the HCFA "Best Practices" guide. Although a third party performs this part of the program function, we believe the agency should consider having a more involved role in this particular feature of the program.

**FINDING 00-CHS-6: The Division Of Substance Abuse Should Establish Procedures To Monitor Progress Reports**

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State Agency: Cabinet for Health Services

Federal Program: CFDA 93.959 - Block Grants for Prevention and Treatment of Substance Abuse

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Entity: Not Applicable

Compliance Area: Subrecipient Monitoring

Amount of Questioned Costs: None

The contract between the Division of Substance Abuse (SA) and CMHC requires progress reports and prevention outcome reports to be submitted by CMHC. In FY 2000, there was a transition by SA from manual reports to electronic reports. Because of this change, there was a hybrid of manual and electronic reporting during the year. However, all these progress reports were not submitted on time. Of the 14 CMHCs:

- 9 did not submit timely electronic progress reports,
- 2 did not submit the manual progress reports,
- 2 did not submit timely manual progress reports,
- 1 did not submit the prevention outcome report, and
- 1 did not submit the prevention outcome report in a timely manner.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-6: The Division Of Substance Abuse Should Establish Procedures To Monitor Progress Reports (Continued)**

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Failure to submit reports and submitting reports late, hinders appropriate program staff from monitoring contract compliance and progress made toward meeting the goals and objectives outlined in the annual Plan and Budget. Reporting failures also skew performance measures periodically calculated by program staff and hinders on-site reviews because priority areas and evaluation of prevention performance measures cannot be identified to investigate during an on-site visit.

OMB Circular A-133 section 400 paragraph (d)(3) requires states to “monitor the activities of subrecipients to ensure that federal awards are used for authorized purposes in compliance with laws, and regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.” One way the SA staff monitors compliance is through subrecipient reporting of their progress and a review of these progress reports. This off-site monitoring provides a base for on-site monitoring of the Substance Abuse Prevention and Treatment (SAPT) block grant subrecipients.

**Recommendation**

We recommend SA develop policies and procedures to follow when subrecipients do not submit progress reports. Reminder letters should be sent when progress reports are not submitted in a timely manner. Per the contract, payments can be withheld for persistent neglect to submit progress reports. We further recommend that these policies and procedures be a part of the contract between SAPT and CMHC.

**Management’s Response and Corrective Action Plan**

*The Division has instituted the following procedures to correct the weaknesses in the monitoring of data reports from the Regional Prevention Centers and Champions.*

- 1. The RPC and Champions Reporting Instructions included in all FY 2001 CMHC contracts communicated the following performance expectation:*

*“Timeliness: 95% of all activities will be entered into the Prevention Data Set (PDS) by the end of the month following their completion.”*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-6: The Division Of Substance Abuse Should Establish Procedures To Monitor Progress Reports (Continued)**

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**Management's Response and Corrective Action Plan (Continued)**

2. *Beginning in February 2000 the Division began producing monthly reports that are sent back to each RPC. The purpose of the reports is to alert both the RPC Directors and Division staff monitoring the programs to the status of the RPC with regard to data submission. Reports were sent each month except for July and October of 2000. During those months, our data system was down for extended periods, hampering our capacity to produce the reports.*
3. *The reports have gone through a number of enhancements since their inception. The enhancements have added information relevant to a number of performance measures that will be calculated for each center at the end of FY 2001.*
4. *Since there is, and cannot be, any definite expectation for the number of data entries per month per center, monitoring focuses on centers that have very low or zero entries for the month. The program monitor scans the monthly data reports for each center, and sends an e-mail inquiry to centers whose data entry appears low. This has been done intermittently to date, but will be done on every month beginning immediately. (See attached Division Policy and Procedure.)*
5. *The following internal Division policy will be instituted immediately to address RPC failure to enter data: If a center fails to provide any data for two consecutive months, a notice will be sent the CMHC Executive Director requesting an investigation of the causes of the problem and given a deadline for corrective action. Payments will be held for non-compliance. (See attached Division Policy and Procedures.)*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-7: The Cabinet For Health Services Should Improve Controls Over Providers**

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State Agency: Cabinet for Health Services

Federal Program: CFDA: 93.778 - Medical Assistance Program

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Entity: Not Applicable

Compliance Area: Allowable Costs

Amount of Questioned Costs: None

The auditor examined 35 types of providers to verify they were eligible to participate in the Medical Assistance Program (MAP). Provider files were reviewed for proper forms and a current license (if required) to determine if the provider is eligible. In some instances, forms were reviewed on a system called Optical Character Recognition-Assisted Data Entry System (OADES). UNISYS has taken over the provider enrollment functions of Medicaid, so this system was put into place. MAP forms, licenses, etc. were imaged into this system so UNISYS can view documents sent in by providers as part of the enrollment process because all provider files are still maintained by the DMS. Based on the auditor's testing, the following exceptions were noted:

- Six files could not be located, nor was any information found in the OADES system.
- Six files did not contain a MAP 343B form.
- Three files did not contain a MAP 380 form when applicable.
- Eight files did not contain a copy of the current license in the file.

In addition to the above testing of various types of providers, the auditor also examined 20 active pharmacies during FY 2000. Provider files were again reviewed for proper forms and a current license. The auditor also verified end dates per the Ad Hoc report obtained during the audit with end dates in the RUMBA system. There were 58 closed pharmacies reviewed during testing. The closed pharmacies were selected from information obtained from the Kentucky State Board of Pharmacy (SBOP). The auditor verified the effective closed date per the SBOP information with the end date in the RUMBA system. It should be noted that the SBOP allows a pharmacy to operate 30 days without a license and the DMS does not end date a pharmacy until 60 days after the effective close date so all claims can be paid to the pharmacy for services rendered.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-7: The Cabinet For Health Services Should Improve Controls Over Providers (Continued)**

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This information was taken into consideration during testing. Based on the auditor's testing, the following exceptions were noted:

- One file did not contain a MAP 380 form as applicable.
- Five files did not contain a copy of the current license in the file.
- Twenty-four of the 58 closed pharmacies tested did not designate the proper end date.

During previous years' audits, there has been a weakness noted for pharmacies not being end dated properly. We recommended that DMS obtain each month a listing from the SBOP of any changes made to pharmacies during that month. This information includes new and closed pharmacies and any name or ownership changes made to a pharmacy. This information was obtained during FY 2000. However, the weakness was still noted by the auditor.

If provider files or the MMIS system is not updated properly, payments for services rendered could be made to ineligible providers. In addition, if provider files are not kept current, personnel may have difficulty ascertaining the status of providers in MAP.

907 KAR 1:672 Section 2 (4)(a) states: "[a]ll applicants for participation shall complete and sign a Provider Agreement, Disclosure of Ownership and Control Interest Statement, Certification with regard to Lobbying Activity, pursuant to 31 USC 1352, provider proof of a valid Professional License Registration, or Certificate which allows the applicant to provide the services for which the applicant contracts, and provide any additional clarifying information requested for processing of the application." Section 3 (4) states: "[t]he provider shall file an amended, signed ownership and disclosure form with the department within thirty-five (35) days from change in the following: (a) Ownership or control; (b) The managing employee or management company; or (c) A provider's federal tax identification number." Section 3 (5) further states: "[f]ailure to comply with the requirements may result in termination from the Medicaid program."

The DMS Pharmacy Manual, page 3.1, specifies, "[a]ny pharmacy holding an operation permit from the Board of Pharmacy in the state in which the pharmacy is located may participate in the Kentucky Medicaid Program." Hence, a pharmacy must have a valid operation permit on file to participate in the Kentucky Medical Assistance Program (KMAP).



**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-7: The Cabinet For Health Services Should Improve Controls Over Providers (Continued)**

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Strong internal controls dictate that a method be established and maintained, which monitors providers on a continuous basis and uses only those providers that have satisfied the eligibility requirements for Medicaid participants. In addition, the controls should be in place so providers are end dated properly to ensure only eligible providers are receiving reimbursement for services rendered.

**Recommendation**

We recommend:

- DMS monitor the provider enrollment functions that have been contracted out to UNISYS more closely. This should include reviewing and updating provider files for the required documents. Failure to do so could allow ineligible providers to be reimbursed.
- DMS institute controls to ensure that all changes to a pharmacy's operational and licensure status be obtained and subsequently updated in the MMIS, where appropriate. This should be done by continuing to obtain information from the SBOP on a monthly basis and by enforcing providers to disclose ownership or control information to UNISYS. Once the information is obtained, appropriate changes should be made to the MMIS.
- Controls be put into place and operate effectively to ensure all providers submit the proper information for their files to be current and in compliance with the conditions to participate in the KMAP.

**Management's Response and Corrective Action Plan**

*The Department for Medicaid Services provider enrollment staff has researched the deficiencies found and has the following response for the June 30, 2000 audit.*

- *Provider enrollment staff has implemented a database on ACCESS to track the providers as they are reviewed during the monitoring of provider enrollment functions. This database also gives us a log to track any problems that Unisys may be having with the provider enrollment process, these problems are then reported to the report care, as well as all actions taken by this office and Unisys to correct this problem.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-7: The Cabinet For Health Services Should Improve Controls Over Providers (Continued)**

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**Management's Response and Corrective Action Plan (Continued)**

- *Unisys produces a weekly report, which is delivered to the provider enrollment staff of the Department for Medicaid Services. This report contains providers that have been newly enrolled in the Medicaid Program and providers who have updated their enrollment. From this list, 10-15 providers are selected for the monitoring of the newly and updating providers for that week. At the end of the month, these applications are compared to the GUI system for accuracy and then logged on the database. If problems are found, Unisys is notified by memo and has 15 days from date of memo to respond with corrective actions taken. Provider enrollment staff receives a box of correspondence changes approximately bi-weekly sometimes monthly. In these boxes are address changes, group crossover additions, etc. From these boxes 20-25 provider numbers are selected to compare to the GUI system for accuracy. Same procedure as the newly enrolled.*
- *Provider enrollment staff receives a box of correspondence changes approximately bi-weekly sometimes monthly. In these boxes are address changes, group crossover additions, etc. From these boxes 20-25 provider numbers are selected to compare to the GUI system for accuracy. Same procedure as the newly enrolled.*
- *The Department for Medicaid Services receives a quarterly report from SBOP. These changes are forwarded to Unisys for appropriate corrections to be made. This is part of the Provider Enrollment monitoring to make sure the SBOP changes are implemented.*
- *DMS Provider Enrollment reviews applications when received from Unisys for approval. Applications are signed to become a participating Kentucky Medicaid provider.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-8: The Department For Medicaid Services Should Comply With The Interagency Agreement With The Office Of Inspector General**

State Agency: Cabinet for Health Services

Federal Program: CFDA 93.778 - Medical Assistance Program

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Entity: Not Applicable

Compliance Area: Special Tests and Provisions

Amount of Questioned Costs: None

The Division of Long-Term Care in DMS is responsible for controlling the utilization of Medicaid Services in institutions. The federally required utilization reviews are performed by the federally designated peer review organization (PRO), which contracts with DMS to provide these services. The PRO is responsible for utilization reviews for Intermediate Care Facilities/Mental Retardation/Developmentally Disabled (ICF/MR/DD) and Skilled Nursing Facilities (SNF). These utilization reviews consist of initial level of care evaluations, on-site reviews, and continued stay determinations.

DMS contracts with the Division of Licensing and Regulation (L&R), a division of the OIG, to provide a quality control mechanism for monitoring the level of care determinations which are made by the PRO on behalf of Medicaid recipients seeking admissions to nursing facilities. During our review of the PRO, we tested the OIG monitoring procedures.

The auditor randomly selected monitoring forms for the third quarter of FY 2000 to review. As required by the Interagency Agreement, L&R submits monitoring forms to the DMS as part of the PRO's monitoring of SNFs. These forms were submitted to the DMS indicating the number of recipients/patients L&R reviewed for each provider.

Our tests were designed to verify monitoring forms were submitted to DMS in accordance with the Interagency Agreement, that is, within 30 days of the previous on-site review. In addition, we determined if the number of recipients reviewed for level of care determinations from the provider agreed with the Monthly Monitoring Summary Form prepared by DMS. Finally, we attempted to determine if L&R submitted a list of the facilities reviewed to DMS no later than the fifth working day of the following month as stipulated in the Interagency Agreement.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-8: The Department For Medicaid Services Should Comply With The Interagency Agreement With The Office Of Inspector General (Continued)**

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The results of our testing noted the following exceptions:

- We tested the entire quarter and determined that 44 of the monitoring forms were not submitted by L&R within 30 days of the last date of on-site review, as is needed in order to be in compliance with the Interagency Agreement.
- Eight of the monitoring forms were never submitted by L&R to DMS.
- DMS did not stamp the received date on eight of the monitoring forms; thus, we could not determine whether the forms were submitted by L&R within 30 days of the last date of on-site review.
- We determined that 726 recipient cases were reviewed by L&R; however, DMS indicated on the Monthly Monitoring Summary Forms 738 recipient cases were reviewed. The number of recipient cases reviewed by L&R should agree with the summary of reviews indicated by DMS.
- In addition, the Monthly Monitoring Summary Forms were not reviewed for completeness by DMS.
- Finally, DMS did not keep a list of the original monthly reports submitted by L&R.

If proper on-site review procedures are not followed by L&R, DMS' responsibility for level of care determinations and utilization control activities in ICF/MR/DDs and SNFs cannot be fulfilled.

Per the Interagency Agreement between the DMS and L&R entered into on July 1, 1999, L&R "shall make an independent level of care determination for each recipient whose file is reviewed and shall forward its findings to the First Party (DMS) within thirty (30) calendar days after the last day of the on-site review". Thus, L&R is responsible for forwarding the Monthly Monitoring Summary Forms to DMS within 30 days after the last day of the on-site review.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-8: The Department For Medicaid Services Should Comply With The Interagency Agreement With The Office Of Inspector General (Continued)**

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In addition, the Interagency Agreement between DMS and L&R states that L&R “will provide the First Party (DMS) the names of the ICF/MR/DD and NF reviewed at the end of each month or no later than the fifth (5<sup>th</sup>) working day of the following month.” Good internal controls dictate that the list of names submitted by L&R be kept as part of DMS’s monitoring process.

Finally, the Long Term Care – Quality Assurance narrative that was updated by DMS personnel for FY 2000 states that “a Medicaid staff member signs the [Summary] report and another employee signs it to verify it has been completed.”

**Recommendation**

We recommend that:

- The Interagency Agreement between OIG, L&R, and DMS be amended to state under “I. Schedule of Facility Review” that OIG provide DMS with the names of the ICF/MR/DDs and SNFs scheduled to be reviewed one month prior to the month scheduled for review. This change would enable DMS to effectively monitor quality control in regards to level of care determinations.
- L&R submit Monthly Monitoring Summary Forms to DMS within 30 days of the last day of the on-site review in order to be in compliance with the Interagency Agreement; thus, meaning that all Monthly Monitoring Summary Forms be submitted properly.
- DMS record on each Monthly Monitoring Summary Form the date that it was received from L&R.
- The Monthly Monitoring Summary Form should be reviewed and signed by two people to verify its completeness.
- The lists submitted by L&R be kept by DMS as part of the monitoring process and to practice acceptable internal controls.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-8: The Department For Medicaid Services Should Comply With The Interagency Agreement With The Office Of Inspector General (Continued)**

**Management's Response and Corrective Action Plan**

*A meeting has been held with OIG to review requirements of the interagency agreement and OIG staff training by DMS has been scheduled.*

*DMS staff have been in-serviced on the necessity of assuring all documents are date-stamped.*

*DMS staff have been in-serviced on the necessity of reviewing all forms for accurate information and to follow-up with the OIG for correction and clarification*

*DMS will keep list of the original monthly reports submitted by L&R.*

**FINDING 00-CHS-9: The Cabinet For Health Services Should Develop Procedures To Ensure Vendors Providing Services To Federal Programs Are Not Debarred Or Suspended By The Federal Government**

State Agency: Cabinet for Health Services

Federal Program: All Federal Assistance Programs

Federal Agencies: U.S. Department of Agriculture, U.S. Department of Justice, U.S. Department of Labor, U.S. Environmental Protection Agency, U.S. Department of Energy, U.S. Federal Emergency Management Agency, U.S. Department of Education, U.S. Department of Health and Human Services, and U.S. Department for National and Community Services

Pass-Through Entity: Not Applicable

Compliance Area: Procurement and Suspension and Debarment

Amount of Questioned Costs: None

CHS did not have a system in place to identify debarred and suspended parties or to prevent them from doing business with state-administered federal programs. This has been a prior year audit finding for CHS and FAC. FAC recently issued a draft policy statement to all state agencies to obtain a certification from successful vendors that they are not debarred from doing business with the federal government prior to award of any contract. CHS has always obtained certification from subrecipients that they are not suspended or debarred before an award is granted. However, CHS has been deficient in ensuring that procurement contracts of \$100,000 or more are not issued to vendors who are suspended or debarred.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Reportable Conditions Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-9: The Cabinet For Health Services Should Develop Procedures To Ensure Vendors Providing Services To Federal Programs Are Not Debarred Or Suspended By The Federal Government (Continued)**

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CHS expected the new accounting system, MARS, to have the capability to identify debarred/suspended vendors. MARS was implemented July 1, 1999; in its present state, it does not have this capability. CHS expected to implement this finding with the implementation of MARS. Thus, no other action was taken to correct this deficiency.

CHS entered into 23 contracts with outside vendors during FY 2000 that were equal to or greater than \$100,000; however, none of these vendors was suspended or debarred. A lack of controls in place to verify whether vendors or potential vendors have been suspended or debarred from transacting business with state administered federal programs could result in CHS conducting business with vendors excluded from federal procurement.

Federal Executive Order 12549 Section 5 requires that the federal government compile a list of debarred and suspended vendors. The Common Rule prohibits agencies receiving federal funds from using these vendors. In addition, OMB Circular A-133 Compliance Supplement Part 3, Section I requires the agency to ensure that contractors receiving more than \$100,000 and all subrecipients certify to the agency that the organization is not suspended or debarred.

**Recommendation**

We recommend CHS implement the policy statement drafted by FAC when it is finalized concerning federal procurements of \$100,000 or more.

**Management's Response and Corrective Action Plan**

*The Cabinet for Health Services concurs with the recommendation that CHS implement the policy statement drafted by the Finance and Administration Cabinet when it is finalized concerning federal procurements of \$100,000 or more.*

*CHS currently obtains certification from its subrecipients and Personal Service Contract holders through a contract clause, which states that by signing the contract, they are not suspended or debarred.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance:**

**FINDING 00-CHS-10: The Department For Medicaid Services Should Strengthen Controls Over Supplementary Medical Insurance Bills**

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State Agency: Cabinet for Health Services

Federal Program: CFDA: 93.778 - Medical Assistance Program

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Entity: Not Applicable

Compliance Area: Activities Allowed or Unallowed

Amount of Questioned Costs: None

During our review of Supplementary Medical Insurance Bills to determine if procedures were in place and operating properly, we discovered that agency personnel failed to reconcile agency level reports to UNISYS reports. The purpose of this reconciliation is to ascertain that valid claims have been properly processed against agency records and properly recorded through UNISYS, third party administrator for Medicaid claims. This was a comment in FY 1999 in that the agency materially misrepresented in their Summary Schedule of Prior Audit Findings and in their corrective action plan.

In Management's Response and Corrective Action Plan for FY 1999, it was stated that

*Ms. (name of employee), who coordinated the functions of the Eligibility area of the Customer Services Branch, is now the individual responsible for performing the reconciliation process of the Medical Insurance Payment reports, forwarding the results of the reconciliation to the Medicaid Division of Financial Systems and acting as recordkeeper for these reports.*

In the Summary Schedule of Prior Audit Findings, the agency stated, "*DMS considers this item to be fully corrected.*"

As noted above, however, our audit work for FY 2000 showed this weakness to persist as originally noted. Neglect to reconcile these reports with UNYSIS could result in errors and material differences could exist and go undetected. A good internal control structure is essential for the achievement of full accountability.

**Recommendation**

We recommend that DMS implement the plan of action originally communicated in the FY 1999 report.



**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-10: The Department For Medicaid Services Should Strengthen Controls Over Supplementary Medical Insurance Bills (Continued)**

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**Management's Response and Corrective Action Plan**

*There was a misunderstanding of the requested information at the time that staff of the Auditor of Public Accounts contacted the appropriate staff of our Department. This Department did implement procedures in April 2000 as indicated in the response to the last audit. The reports are provided to the Division of Member and Provider Services, Customer Services Branch. She is responsible for monitoring and ensuring that the Unisys financial reports are reconciled accurately and timely.*

*Additionally, copies of the monthly reports and corresponding summary accounts, accompanied by the signed cover memorandum are maintained in the Customer Services Branch. Customer Service Branch staff contacted the auditor again on July 9, 2001 and explained that they had the information for review. The auditor received the reports on July 9 and again on July 10, 2001. He inquired about the discrepancies found between the Unisys Medicaid Management Information Systems Report and the Agency 180 log. E-mail was submitted requesting clarification regarding the dollar amount discrepancies, to the Division of Information Systems. The auditor requested that we document the reason(s) for any future discrepancies on the Unisys reports. This should rectify any future reconciliation inquiries.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-11: The Department For Medicaid Services Should Improve Controls Over Nursing Facilities To Comply With Federal Regulations**

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State Agency: Cabinet for Health Services

Federal Program: CFDA: 93.778 - Medical Assistance Program

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Entity: Not Applicable

Compliance Area: Special Tests and Provisions

Amount of Questioned Costs: None

During the testing of internal controls and compliance of nursing facilities for meeting prescribed health and safety standards, we found that eight (8) out of fifty-six (56) nursing facilities were not surveyed within fifteen (15) months of the previous survey.

Nursing facilities could be ineligible to participate in the Medicaid program because they are not surveyed and recertified properly.

42 CFR 488.308 states that the survey agency must conduct a standard survey of each skilled nursing facility (SNF) and nursing facility (NF) no later than 15 months after the last day of the previous standard survey.

**Recommendation**

We recommend that surveys be conducted within the 15 months so that each SNF and NF is recertified and eligible to participate in the Medicaid program.

**Management's Response and Corrective Action Plan**

*Upon reviewing the Audit Report, there appear to be the following discrepancies in the information provided: missing survey dates; incorrect survey dates documented; fire marshal office dates used instead of survey agency dates; and one nursing facility not licensed or certified as nursing facility.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-11: The Department For Medicaid Services Should Improve Controls Over Nursing Facilities To Comply With Federal Regulations (Continued)**

**Management's Response and Corrective Action Plan (Continued)**

*A review of our records indicate that your office was not provided with the most current survey dates Oakwood ICF/MRDD, Christian Health Center, Britthaven of South Louisville, Corbin Nursing Home and JB Haggin Hospital. In addition, you were provided with incorrect dates for the review of Mills Manor Nursing Home. Review of our records revealed no facility licensed or certified as a nursing facility by the name of Caldwell County Hospital Incorporated. Please see Attachment 3, which illustrates correct survey dates for all the facilities in question. Corrections noted here should be reflected in your Report.*

*Based on your information, our Office acknowledges that with two facilities, Vanceburg Health Care Center and Christian Health Center, surveys exceeded a fifteen month average. Vanceburg Health Care Center number of months between surveys using the Health Care Financing Administration (HCFA) formula is 15.39 instead of 15.7 and Christian Health Center with the additional survey dates is at 15.35 instead of 29.7 between the current and prior surveys.*

*As part of our quality assurance process, the Office of Inspector General, Division of Long Term Care, completes a tentative survey schedule prior to the beginning of the federal fiscal year. Additionally, we recognize the challenge of surveying facilities within a 15-month timeframe. As of July 1, 1999, we began to increase our survey staff in order to meet the state and federal timeframes. Monitoring of these timeframes will continue to be an important part of our quality assurance process.*

*I hope the information that has been provided will assist in clarifying your concerns. In the future, we encourage your staff to contact us for the most current and accurate information concerning surveys and the HCFA survey process.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-11: The Department For Medicaid Services Should Improve Controls Over Nursing Facilities To Comply With Federal Regulations (Continued)**

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**Auditor's Reply**

The auditor took the information given in response to the RCW that was submitted and verified it with information in the provider files maintained by Medicaid. Through further review of the original eight exceptions noted, it appears that there are still seven exceptions noted where surveys were not performed within the 15 month timeframe. The nursing facility that was noted as not being certified or licensed is still active according to Medicaid's records. We recommend that if nursing facilities are no longer certified or licensed, that proper notice be given to DMS so its provider enrollment files are accurate and current. During the review, it was noted that one hospital was issued a new provider number. The new provider number was the number the auditor had access to during testing. The old number was reviewed for survey dates. In the file, the auditor noted that surveys were properly performed on this facility. Therefore, no exception is noted.

For DMS to properly determine eligibility status of a provider, the most accurate and current information should be obtained in the provider files. Therefore, if the OIG, Division of Licensing and Regulation has a responsibility to license such facilities, proper documentation should be forwarded to DMS to ensure these controls are in place and operating effectively.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-12: The Department For Medicaid Services Should Improve Controls Over In State Hospitals To Comply With Federal Regulations**

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State Agency: Cabinet for Health Services

Federal Program: CFDA: 93.778 - Medical Assistance Program

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Entity: Not Applicable

Compliance Area: Allowable Costs/Cost Principles

Amount of Questioned Costs: None

During the testing of internal controls and compliance of in-state hospitals for determining whether hospitals had been adequately surveyed and recertified, we found that five (5) out of our sample of forty-five (45) JCAHO accredited in-state hospitals were not surveyed within 36 months of the previous survey for recertification purposes. Fourteen (14) of the forty-five (45) were surveyed during FY 2000. Of the ten (10) unaccredited in-state hospitals, there were eight (8) not surveyed within 12 months of the previous survey. There were ten (10) unaccredited hospitals in this year's sample and five (5) of them were surveyed during FY 2000. Of the five (5) that were not surveyed, two (2) have not been surveyed since 1997, two (2) since 1998, and the remaining one since the early part of 1999. In addition, it was noted that eight (8) in-state hospitals were not surveyed during FY 2000 that should have been.

In-state hospitals could be ineligible to participate in the Medicaid program because they are not surveyed and recertified according to the regulations. .

42 CFR 488.5 states that JCAHO accredited hospitals should be surveyed within 36 months of the previous survey to be recertified. In addition, unaccredited hospitals should be surveyed within 12 months of the previous survey to remain certified and able to participate in the Medicaid program.

**Recommendation**

We recommend that surveys be conducted within the appropriate time periods in order to be recertified and eligible to participate in the Medicaid program.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-12: The Department For Medicaid Services Should Improve Controls Over In State Hospitals To Comply With Federal Regulations (Continued)**

**Management's Response and Corrective Action Plan**

*The Audit Report indicates that 5 of 45 Joint Commission on Accreditation of Hospitals (JCAHO) accredited hospitals were not surveyed within 36 months of the previous survey. It further states that 14 of 45 accredited hospitals were surveyed during FY 2000. 42 CFR 488.5 (Attachment 1) provides that JCAHO accredited hospitals are deemed to be in compliance with certification conditions of participation. Validation surveys are occasionally conducted to ensure that compliance is maintained.*

*The survey interval for Medicare/Medicaid certified health facilities is determined by the State Survey and Certification Budget Call Letters (Attachment 2) which are sent to state survey agencies each year by the Health Care Financing Administration (HCFA). The Budget Call Letters for FY 2000 and FY 2001 mandated that validation surveys be conducted on 5 percent of accredited hospitals. Since this goal was exceeded, the HCFA mandate was met. Contrary to the Report, 42 CFR 488.5 does not state "that JCAHO accredited hospitals should be surveyed within 36 months of the previous survey to remain certified and able to participate in the Medicaid program." Since there is no mandate that surveys be conducted of JCAHO accredited hospitals within 36 months of the previous survey, this area of noncompliance should be removed from the Report.*

*The Report further states that of the 10 non-accredited hospitals reviewed, 8 were not surveyed within 12 months of the previous survey and 5 of 10 sampled were not surveyed during FY 2000. The HCFA Budget Call Letters referenced above require the state agency to survey 33 percent of accredited hospitals during FY 2001 and 11 percent during FY 2000. This mandate was met during both of these fiscal years. Since the report is incorrect and there is no requirement that non-accredited hospitals must be surveyed within 12 months of the previous survey, this area of non-compliance should also be removed from the Report.*

*Although it is the goal of this office to survey hospitals on an annual basis, these hospitals do not have time-limited agreements. Annual surveys of these hospitals have no effect on their certification status. We are meeting HCFA-maintained goals for hospital survey intervals.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-12: The Department For Medicaid Services Should Improve Controls Over In State Hospitals To Comply With Federal Regulations (Continued)**

**Auditor's Reply**

Through further review, it is apparent that there is no requirement for hospitals to be surveyed within either 12 months or 36 months of a previous survey. However, an annual license is issued to hospitals (for both accredited and non-accredited). Per discussion with personnel and review of provider enrollment files, a copy of the license is not sent to the Department of Medicaid Services. In order to properly determine that a hospital is eligible to participate in the Medicaid program, this information should be maintained in the file. Therefore, the OIG, Division of Licensing and Regulation should forward this information to the proper provider enrollment personnel in DMS. In addition, when conducting surveys in accordance with HCFA standards, the sample should be rotated so that a survey is conducted on all hospitals once every three years. This would ensure good internal controls are being practiced. Once the survey has been conducted, the information should be forwarded to DMS so their provider enrollment files are accurate and current.

**FINDING 00-CHS-13: The Cabinet For Health Services Should Strengthen Controls In Preparing The Schedule Of Expenditures Of Federal Awards**

State Agency: Cabinet for Health Services

Federal Program: CFDA: 93.778 - Medical Assistance Program

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Entity: Not Applicable

Compliance Area: NA

Amount of Questioned Costs: None

In our audit of CHS' Schedule of Expenditures of Federal Awards and the accompanying notes, we noted the following errors and omissions:

- The schedule did not include the pass-through agencies or the amounts that were passed-through to these agencies. In addition, CHS did not maintain the necessary accounts to identify its pass-through entities on the schedule.
- The notes to the schedule did not include all the amounts transferred to and from other agencies. Payments to subrecipients for six programs shown in the notes did not agree with program expenditures in the schedule.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-13: The Cabinet For Health Services Should Strengthen Controls In Preparing The Schedule Of Expenditures Of Federal Awards (Continued)**

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- Payments to subrecipients in the notes were shown for one program, but there were no expenditures in the schedule for that program.

The errors occurred because there was no independent review of the schedule and the notes. Grant accountants provided the expenditures amounts for the schedule, while program personnel provided the amounts of payments to the subrecipients in the notes. The grant administrator reconciled the expenditures in the schedule to MARS, but no other review or reconciliation was performed.

Omissions, in part, occurred because the state's new accounting system, MARS, did not record transfers to and from other state agencies. A further cause appears to be that the grant accountants did not keep records of transfers in and out. Grant accountants relied upon the state accounting system to provide this information.

Paragraph 5.3 of the Statement of Position (SOP) 98-3 states that:

“OMB Circular A-133 also requires the auditee to identify in its accounts all federal awards received and expended, as well as the federal programs under which they were received. Federal programs and award identification includes, as applicable, the CFDA title and number, the award number and year, the name of the federal granting agency, and the name of the pass-through entity.”

Paragraph 5.11 of SOP 98-3 further states that:

“. . . OMB Circular A-133 requires the schedule to include the name of the pass-through entity and the identifying number assigned by the pass-through entity for federal awards received as a subrecipient.”

The notes to the schedule should also disclose the amount of the transfer and to whom it was transferred.



**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-13: The Cabinet For Health Services Should Strengthen Controls In Preparing The Schedule Of Expenditures Of Federal Awards (Continued)**

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**Recommendation**

We recommend CHS discuss with MARS personnel ways to enable agencies to obtain adequate data from MARS on amounts transferred to and from agencies. Until this occurs, CHS should maintain records to account for all amounts transferred to and from other agencies. CHS should also provide the pass-through agencies and amounts in the schedule and disclose all transfer amounts in and out in the notes to the schedule.

We further recommend CHS conduct an independent review of the schedule and the notes to ensure they are accurate, complete, and in compliance with OMB Circular A-133. This review would involve comparing amounts in the notes to amounts shown in the schedule. We also recommend that evidence of this review and reconciliation be retained.

**Management's Response and Corrective Action Plan**

*The STARS system Transfer In and Transfer Out data aligned with the Schedule of Expenditures of Federal Awards. The MARS system methodology for posting Revenue is substantially changed in comparison to STARS.*

*The MARS system manages the federal receipts by directly crediting (posting) the Revenue to the respective Agency's federal account that is performing the activity. The funds are deposited directly and do not pass through the primary agency's accounts. The only exception is when another state agency does not utilize the Project Billing component of MARS.*

*Our recommendation is to have SEFA reflect the following changes: 1) Column labeled "Cash Receipts" be changed to "Cash Receipts drawn by Agency," 2) Add column labeled "Cash Receipts drawn by Other Agencies," and 3) Add column labeled "Cash Drawn for Other Agencies."*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-13: The Cabinet For Health Services Should Strengthen Controls In Preparing The Schedule Of Expenditures Of Federal Awards (Continued)**

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**Management's Response and Corrective Action Plan (Continued)**

*Additionally, a meeting with the Auditor of Public Accounts and State Agencies to address the issues prior to issuing SEFA instructions for SFY 2001 is very critical.*

*The Cabinet for Health Services developed the Schedule of Expenditures of Federal Awards (SEFA) in accordance with the instructions provided from the Auditor of Public Accounts (APA). We included the transfers in and out that were applicable to the STARS system. All other activity within the Management Administrative Reporting System (MARS) was reported as the system captured the data. Our schedule reflected true Revenue activity as reflected in MARS.*

*The MARS system has within the Project/Grants module an Entity-Wide number for each grant. Components of the grant are captured in the respective project/grant module and are attached within the MARS system, so the Cabinet does have the ability to obtain adequate data on amounts received by other agencies in relation to our grants and on amounts drawn by other agencies that was directly received by us.*

*The Cabinet believes the Auditor of Public Accounts should modify instructions to accurately reflect MARS activity by Agency since our SEFA needed enhancements per this RCW.*

*The Cabinet For Health Services concurs with the recommendation to conduct an independent review of the Subrecipient component of SEFA. Henceforth, we will perform an independent review of the Subrecipient Data before submitting to the Auditor of Public Accounts.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-13: The Cabinet For Health Services Should Strengthen Controls In Preparing The Schedule Of Expenditures Of Federal Awards (Continued)**

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**Auditor's Reply**

The Agency's response is based upon the premise that "The Cabinet for Health Services developed the Schedule of Expenditures of Federal Awards (SEFA) in accordance with the instructions provided from APA. We included the transfers in and out that were applicable to the STARS system."

This statement contains the elements of several of our audit findings. First, the APA sent instructions that covered each FFA. The instructions for FFA 2 – Schedule of Expenditures of Federal Awards (Cash) on page 13 - 1) "Report on this schedule all federal awards received in the form of cash. Federal financial awards is defined by the Act as ' . . . federal financial assistance . . . 'Assistance means that non-federal entities receive or administer in the form of grants . . . 'The instructions further state, 'These awards may be received directly from the federal grantor or as a pass through from another state agency (emphasis added) or local governmental unit."

The instructions continue on page 15 - 13) Column F – "Transfers in (including revenue redistribution) should consist of federal moneys received from other federal grants (either from inside the agency or from another state agency) to fund federal expenditures. When an agency is a subrecipient of another agency, those moneys received should be shown in this column."

"All amounts in this column must be explained in the Notes. (See Sample FFA 4.)"

Instructions for transfers out are found on page 16 – 17) Column J. These instructions are similar to those for transfers in Column F, except these are for transfers out.

We believe CHS focused exclusively on the state's new accounting system, MARS, which does not clearly account for transfers in and out, and overlooked the APA instructions and, more importantly, OMB A-133 Compliance requirements.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-13: The Cabinet For Health Services Should Strengthen Controls In Preparing The Schedule Of Expenditures Of Federal Awards (Continued)**

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**Auditor's Reply (Continued)**

These requirements are explained in the AICPA Audit and Accounting Guide's Audits of State and Local Governmental Units, with Conforming Changes as of May 1, 2000. Statement of Position 98-3 states in Chapter 5, Schedule of Expenditures of Federal Awards, Section 3, Auditee Requirements, that "Circular A-133 also requires the auditee to identify in its accounts all federal awards received and expended, as well as the federal programs under which they were received. Federal programs and award identification includes, as applicable, the CFDA title and number, the award number and year, the name of the federal granting agency, and the name of the pass-through entity."

CHS suggests that the APA modify the instructions to accurately reflect MARS activity by CHS. We are currently reviewing the schedule instructions for FY 2001, and hope to make our instructions more clear and consistent with the new accounting data and terminology. However, the agency is still required to comply with the requirements of A-133 regarding pass-through activity, despite difficulties in interpreting the schedule instructions.

In addition, the CHS should recognize that the Schedule of Expenditures of Federal Awards is federally mandated and the requirements regulating the schedule are federal. The lack of MARS applications that track transfers in and out is not a legitimate excuse for not following the federal requirements. As we recommended in our comment, CHS should undertake to implement changes in MARS to address this deficiency if MARS is critical to the preparation of schedule.

Finally, we agree with the suggestion for conducting a meeting with state agencies. Such a meeting could remedy significant schedule problems that the APA has encountered.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-14: The Department Of Public Health Should Strengthen Controls Over The Visual Edit Checks Of Food Instruments**

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State Agency: Cabinet for Health Services

Federal Program: CFDA: 93.778 - Medical Assistance Program

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Entity: Not Applicable

Compliance Area: Special Tests and Provisions

Amount of Questioned Costs: None

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) issues food instruments (FI) that are used in lieu of cash for predetermined food purchases at approved retail stores. The store accepts the food instruments as if they were checks and includes them with the regular bank deposits. The food instruments circulate through the banking system and are received by the state's paying agent, Farmers Bank & Capital Trust Company in Frankfort. Farmers Bank performs a visual edit check on the food instruments for accuracy and rejects any FIs if they do not meet program requirements. Reasons for rejection include a missing agency or vendor stamp; stale check; date redeemed invalid, missing, or altered; and signature missing or not matching. WIC management allows the bank a one percent error rate on their visual edit process for paid food instruments that should have been rejected.

The Food Instruments Paid in Error report has contained error rates that ranged between 1.5 and 2.79 percent for eight of the twelve quarters since January 2, 1998. An error rate over one percent is a red flag that something is wrong and should be reported to the Program Operations Section. The continued reporting of higher error rates suggests that the internal controls over FIs paid in error have failed. The higher reported error rates have either not been reported to the Program Operations Section or the Section has not satisfactorily resolved the problem that is causing the error rates to be recorded at the higher rates.

WIC management has stated that the reported error rate is incorrect. While this may be true, the fact that the error rate, correct or incorrect, continued to exist without an attempt to determine why the rates were high is cause for concern.

The agency has been recording on the Food Instruments Paid in Error report that the bank is paying food instruments that should have been rejected at up to twice the allowable error rate. The failure to monitor the bank's reported higher error rate has allowed a risk that truly invalid FIs may be erroneously paid.

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-14: The Department Of Public Health Should Strengthen Controls Over The Visual Edit Checks Of Food Instruments (Continued)**

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WIC policy, as stated in the APA narrative #1, Food Instrument Delivery Services, is to allow Farmers Bank a one percent error rate on their visual edits of food instruments that should be rejected but were paid. In addition, good internal control dictates that the error rate should be as low as feasibly possible, since even a one percent error rate could produce a half-million dollars a year in erroneously paid food instrument. This error rate report is a good management tool that should not be ignored.

**Recommendation**

We recommend that WIC management personnel review the visual edit procedures of Farmers Bank's edits, recalculate the reported error rates to determine the validity of the reported higher rates, and institute corrective actions to ensure the reported error rates are accurate.

**Management's Response and Corrective Action Plan**

*WIC management has already taken recommended steps. Those steps include:*

- WIC management personnel reviewed procedures surrounding the calculation by WIC personnel of the error rate for the visual edits of the WIC Program food instruments by Farmers Bank and discovered and corrected the error in procedures.*
- WIC personnel recalculated the error rate for the time period January 1998 to January 2001.*
- WIC personnel used the proper procedures to review April and July of 2001.*

*The recommendations have already been instituted. The error by the bank for the visual edits of the food instruments is well within the 1% tolerance.*

**CABINET FOR HEALTH SERVICES  
SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

**SECTION 3 - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

**Other Matter Comments Relating To Internal Control And Compliance: (Continued)**

**FINDING 00-CHS-14: The Department Of Public Health Should Strengthen Controls Over The Visual Edit Checks Of Food Instruments (Continued)**

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**Auditor's Reply**

We agree with the agency's statement "action had been taken to address these issues . . ."

This statement addresses the incorrect counts and percentages reported on the Food Instruments Paid in Error report and we recognize the corrected figures provided by WIC management.

This comment, however, is not about the incorrect figures on the report. It is about why the error rate, correct or incorrect, continued to exist at rates as high as 2.79 percent from January 1998 to the present without an attempt by WIC management to determine why the rates were high. If the error rates had been the rates reported, the WIC program would have lost over one million dollars a year by paying food instruments that should not have been paid.

The response by WIC management does not specifically address this concern. We hope that WIC management will recognize that not only do the figures need to be corrected, but also that the controls that were put in place to alert management of a problem with the food instruments paid in error should not be ignored.

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**SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS**



**CABINET FOR HEALTH SERVICES  
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS  
FOR THE YEAR ENDED JUNE 30, 2000**

<b>Fiscal Year</b>	<b>Finding Number</b>	<b>Finding</b>	<b>CFDA Number</b>	<b>Questioned Costs</b>	<b>Comments</b>
<b><u>Reportable Conditions</u></b>					
<i>(1) Audit findings that have been fully corrected:</i>					
FY 99	99-CHS-1	The Year-End Cash Balance For	N/A	\$0	Resolved during
	99-CHS-23	The County Health Central Bank Account Should Be Reported			FY 2000.
FY 99	99-CHS-2	The Office Of The General	N/A	0	Resolved during
	99-CHS-24	Counsel Should Improve Controls Over Contingent Liabilities			FY 2000.
FY 99	99-CHS-4	The Department Of Medicaid	N/A	0	Resolved during
	99-CHS-26	Services Should Strengthen Controls Over The Kentucky Health Care Program			FY 2000.
FY 99	99-CHS-8	The Cabinet For Health Services	N/A	0	Resolved during
	99-CHS-37	Should Improve Subrecipient Monitoring Procedures At The Department For Public Health			FY 2000.
FY 98	98-CHS-5	Subrecipient Monitoring	N/A	0	Resolved during
	98-CHS-33	Procedures At The Department For Public Health Should Be Improved			FY 2000.
FY 98	98-CHS-6	The Department Of Public Health	N/A	0	Resolved during
	98-CHS-34	Should Develop Written Policies and Procedures For Significant Areas Of The Immunization Program			FY 2000.
<i>(2) Audit findings not corrected or partially corrected:</i>					
FY 99	99-CHS/CDP-27	Custom Data Processing, Inc. Should Require Formal Requests For All Program Changes	N/A	0	It was noted that requested changes must be in written format; however, this procedure is not followed consistently.

**CABINET FOR HEALTH SERVICES  
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

<b>Fiscal Year</b>	<b>Finding Number</b>	<b>Finding</b>	<b>CFDA Number</b>	<b>Questioned Costs</b>	<b>Comments</b>
<b><u>Reportable Conditions</u> (Continued)</b>					
<i>(2) Audit finding not corrected or partially corrected:(Continued)</i>					
FY 99	99-CHS-7 99-CHS-36	The Department For Medicaid Services Should Improve The Controls Over Drug Rebate Billings, Collections, And Recording	N/A	\$ 0	During our review of this area of the Medicaid program, we noted that the agency had implemented its corrective action for some of the weaknesses indicated in the prior year. However, we continue to note problems with both the corrective actions and other areas within the Drug Rebate Program.  See finding 00-CHS-5.
FY 98	98-CHS/CDP-1	Custom Data Processing, Inc. Should improve Logical Access Security Procedures for the Cabinet for Health Services System Application	N/A	0	No changes were noted during FY 2000.
FY 97	97-CHS-49	The Department For Public Health Should Develop A Complete Information System Security Policy	N/A	0	Some progress was made in this area; however, there is no formal information system security policy in place.
FY 96	N/A	The Department For Medicaid Services Should Improve Internal Controls Relating To The Alternative Intermediate Care/Mental Retardation Waiver	N/A	120,760	The agency has implemented our corrective action plan. The questioned cost has not been resolved.

**CABINET FOR HEALTH SERVICES  
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

<b>Fiscal Year</b>	<b>Finding Number</b>	<b>Finding</b>	<b>CFDA Number</b>	<b>Questioned Costs</b>	<b>Comments</b>
<b><u>Reportable Conditions</u> (Continued)</b>					
<b><i>(3) Corrective action taken is significantly different from corrective action previously reported:</i></b>					
FY 97	97-CHS-47	The Finance And Administration Cabinet And The Cabinet For Health Services Should Develop Procedures To Ensure Vendors Providing Services To Federal Programs Are Not Debarred Or Suspended By The Federal Government	N/A	\$0	The agency did not implement their corrective action plan. MARS did not have the capacity to identify suspended/debarred vendors. See finding 00-CHS-9.
<b><i>(4) Audit finding is no longer valid or does not warrant further action:</i></b>					
FY 99	99-CHS-3	The Department Of Medicaid Services Should Improve Control Procedures Over The Medical Assistance Program	N/A	0	Due to improvements, this finding was downgraded to an other matter finding for FY 2000. This finding is no longer required to be reported under <i>Government Auditing Standards</i> .
	99-CHS-25				
FY 97	97-CHS-44	The Department For Medicaid Services Should Improve The Controls Over Drug Rebate Billings, Collections, And Recording	N/A	0	See comments for 99-CHS-7.
FY 97	97-CHS-48	The Division Of Substance Abuse Should Adhere To Established Internal Control Procedures	N/A	0	The agency has changed from a manual system to an electronic progress reporting system. Problems were found in the electronic system, however. See finding 00-CHS-6.

**CABINET FOR HEALTH SERVICES  
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

<b>Fiscal Year</b>	<b>Finding Number</b>	<b>Finding</b>	<b>CFDA Number</b>	<b>Questioned Costs</b>	<b>Comments</b>
<b><u>Material Weaknesses/Noncompliance's</u></b>					
<b><i>(1) Audit findings that have been fully corrected:</i></b>					
FY 98	98-CHS/CDP-11	Custom Data Processing, Inc. Should Update All Systems To Be Year 2000 Compliant	N/A	\$0	Due to improvements, this finding was downgraded to another matter finding in FY 1999. This finding is considered resolved for FY 2000.
FY 98	98-CHS-7 98-CHS-42	The Department Of Public Health Should Strengthen Controls Over The Vaccine Inventory System	N/A	0	Resolved during FY 2000.
<b><i>(2) Audit findings not corrected or partially corrected</i></b>					
No findings for this section.					
<b><i>(3) Corrective action taken is significantly different from corrective action previously reported:</i></b>					
No findings for this section.					
<b><i>(4) Audit finding is no longer valid or does not warrant further action:</i></b>					
FY 97	97-CHS-55	The Department For Medicaid Services Should Establish Procedures To Ensure That Pharmacy Provider Information Is Accurate And Current In The Medicaid Management Information System	N/A	0	Due to improvements, this finding was downgraded to another matter finding in FY 1999. This finding is no longer required to be reported under <i>Government Auditing Standards</i> and OMB Circular A-133.

**CABINET FOR HEALTH SERVICES  
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

<b>Fiscal Year</b>	<b>Finding Number</b>	<b>Finding</b>	<b>CFDA Number</b>	<b>Questioned Costs</b>	<b>Comments</b>
<b><u>Other Matters</u></b>					
<i>(1) Audit findings that have been fully corrected:</i>					
FY 99	99-CHS-6	The Cabinet For Health Services Should Improve Controls Over Personnel and Payroll Functions	N/A	\$0	Resolved during FY 2000.
FY 98	98-CHS-14	The Department For Medicaid Services Should Strengthen Controls Over The Home And Community Based Waiver	N/A	0	Resolved during FY 2000.
FY 98	98-CHS-15	The Department For Medicaid Services Should Improve Recordkeeping And Monitoring Of HCFA-1539 Form Certifications	N/A	0	Resolved during FY 2000.
FY 98	98-CHS-18	The Department For Medicaid Services Should Ensure That Ad Hoc Reports From Unisys Are Timely and Accurate	N/A	0	Resolved during FY 2000.
FY 98	98-CHS-22	The Department Of Public Health Should Improve Controls Over The Special Supplemental Nutrition Program For Women, Infants, and Children	N/A	0	Resolved during FY 2000.
<i>2) Audit findings not corrected or partially corrected</i>					
FY 99	99-CHS-5	The Cabinet For Health Services Should Improve Controls Over Providers	N/A	0	DMS contracted provider eligibility to UNISYS. Problems with provider eligibility and updating the MMIS have persisted since FY 1997. This finding is upgraded to reportable. See finding 00-CHS-7.

**CABINET FOR HEALTH SERVICES  
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

<b>Fiscal Year</b>	<b>Finding Number</b>	<b>Finding</b>	<b>CFDA Number</b>	<b>Questioned Costs</b>	<b>Comments</b>
<b><u>Other Matters</u> (Continued)</b>					
<b><i>2) Audit findings not corrected or partially corrected: (Continued)</i></b>					
FY 99	99-CHS-9	The Department For Medicaid Services Should Comply With The Interagency Agreement With The Office of Inspector General	N/A	\$0	The agency is in the process of implementing our recommendation. However, other problems were noted in FY 2000. This finding is upgraded to reportable. See finding 00-CHS-8
FY 99	99-CHS-10	Internal Control Over In-State Hospitals Should Be Strengthened To Insure Compliance With Regulations	N/A	0	Similar problems were noted in FY 2000. The finding was delivered to OIG instead of DMS for response. An auditor reply was prepared. See finding 00-CHS-12.
FY 99	99-CHS-11	Internal Control Over The Managed Care Program Should Be Improved	N/A	0	Implementation of the Medicaid Quality Tracking System has been delayed until January 2001.
FY 99	99-CHS-12	The Department For Medicaid Services Should Strengthen Controls Over Supplementary Medical Insurance Bills	N/A	0	No reconciliation of agency level reports to UNISYS reports has been performed. See finding 00-CHS-10.
FY 98	98-CHS-10	The Department For Medicaid Services Should Improve Controls Over Nursing Facilities To Comply With Regulations	N/A	0	Similar problems were noted in FY 2000. The finding was delivered to OIG instead of DMS for response. An auditor reply was prepared. See finding 00-CHS-11.

***(3) Corrective action taken is significantly different from corrective action previously reported:***

No findings for this section.



**CABINET FOR HEALTH SERVICES  
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS  
FOR THE YEAR ENDED JUNE 30, 2000  
(CONTINUED)**

<b>Fiscal Year</b>	<b>Finding Number</b>	<b>Finding</b>	<b>CFDA Number</b>	<b>Questioned Costs</b>	<b>Comments</b>
<b><u>Other Matters</u> (Continued)</b>					
<b>4) Audit finding is no longer valid or does not warrant further action:</b>					
FY 98	98-CHS-8	The Department Of Public Health Should Improve Controls Over The Bank Reconciliation Process	N/A	\$0	The bank account was closed July 1, 2000.
FY 98	98-CHS-9	The Department O Public Health Should Close Its County Health Central Bank Account	N/A	0	The bank account was closed July 1, 2000.
FY 98	98-CHS-20	The Department For Public Health Should Develop A Formal Disaster Recovery Plan	N/A	0	A Business Recovery Plan has been issued. There are some minor issues that still need to be addressed. The finding is downgraded to verbal for FY 2000.